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Zeroing In on Women's Health

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The International Foundation of Employee Benefit Plans is the premier educational organization dedicated to providing the diverse employee benefits community with objective, solution-oriented education, research and information to ensure the health and financial security of plan beneficiaries worldwide.

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in this issue

contributors

As the makeup of the workforce changes to include more women in the trades, authors **Joanna Balogh-Reynolds** and **Stacey Hofert** suggest that multiemployer benefit plans may want to invest in expanded benefits to support well-being across a woman's lifetime. Benefits to consider include programs that provide support for fertility and family building, maternity health and menopause. Balogh-Reynolds is the vice president of product strategy at Progyny, where Hofert is the group vice president of labor and trust.

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Could artificial intelligence (AI) hold the key to securing employee benefit plan member data? **Laurent Laor**, chief executive officer and founder of Viveka Health, writes that benefit plans can likely tap AI solutions to authenticate member data while improving plan member experience when accessing their benefits information online.

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Making sure that an employee benefit plan is prepared for a crisis—whether it's a natural disaster or a man-made event such as a cyberattack—is part of a plan sponsor's fiduciary duty, **Christopher J. Rosetti, CFE, CFF, CPA**, explains. Rosetti, who is the chief operating officer of the New York State Nurses Pension Plan and Benefits Fund in Albany, New York, discusses essential elements of crisis planning, including risk assessment, crisis management, and business continuity and recovery. Rosetti was a co-presenter of a session on crisis management at the Trustees and Administrators Institutes in 2024.

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Using reference-based pricing (RBP) to pay health care providers may help reduce health care costs for plan sponsors and plan participants. Attorneys **Christine M. Cooper** and **Jack M. Towarnicky, CEBS**, outline the benefits and challenges of RBP and suggest a three-phase approach for implementation. Cooper is the founder and chief executive officer of aequum LLC, where Towarnicky is an Employee Retirement Income Security Act (ERISA) and employee benefits compliance and planning attorney.

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Collaborating with employee resource groups (ERGs) can help employers design and deliver financial wellness programming that reflects employees' unique experiences, author **Liz Davidson** explains. Davidson, who is the chief executive officer of Financial Finesse, draws on the experience of several large employers to highlight several best practices for leveraging ERGs in financial wellness. Financial Finesse is a financial wellness program provider based in El Segundo, California.

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benefit trends | successful wellness initiatives

by | **Kathy Bergstrom, CEBS**, and **Tyler Lloyd, GBA**

The COVID-19 pandemic changed everything for the wellness program offered by The School District of Palm Beach County (SDPBC) in Florida—and for the better, according to Carlye Fabrikant, the district's wellness coordinator.

On the very first day of lockdown in March 2020, Fabrikant admitted that she was uncertain about how she would do her job or whether anyone could participate since wellness activities tend to rely on in-person involvement. But she quickly responded by creating virtual wellness programming for the SDPBC staff of 25,000. "Over the first year of the pandemic, we did 100 virtual workshops—all on different topics—and they loved it."

"It seems like all staff are busier and busier, and people are not prioritizing their health in their spare time. The virtual offering allows them to be connected and doesn't take them away from their jobs."

Carlye Fabrikant
Wellness Coordinator
The School District of Palm Beach County
West Palm Beach, Florida

Staff were hungry to make connections with others, and the virtual offerings continued as schools reopened and people returned to work. "Five years later, we're not doing as many virtual workshops, but it opened the door for what wellness could be," Fabrikant noted.

Wellness programs, like those offered by the school district, were the focus of *Workplace Wellness and Financial Education: 2025 Survey Report* from the International Foundation of Employee Benefit Plans. Nearly two-thirds (62%) of organizations responding to the survey said they provide wellness initiatives because they want to improve worker health and well-being and workplace culture, while only 28% of organizations said controlling/reducing health-related costs was their motivation.

The report reveals the most common wellness initiatives among corporations/single employer plans, multiemployer funds and public employer plans. Other topics covered include common barriers to success, strategies for measuring outcomes, wellness budgets and more.

Top Initiatives

Wellness encompasses many facets of life, such as physical, emotional, social, work, financial and spiritual; therefore, the types of wellness initiatives organizations offer vary. Following is a look at the top three initiatives identified by survey respondents in several categories.

- Fitness and nutrition
  - –Standing/walking workstations
  - –Wellness competitions
  - –Ergonomic training/supports, workstations
- Mental health
  - –Mental health coverage
  - –Employee assistance programs
  - –Substance use disorder treatment coverage/benefits
- Health screening and treatment
  - –Flu shots
  - –Health screenings
  - –Health risk assessments/appraisals
- Social and community health
  - –On-site events/celebrations
  - –Community charity drives/events
  - –Community volunteer projects

Successful Wellness Initiatives

Survey respondents were asked to identify their most successful initiatives as well as unique offerings, and responses ranged from traditional health fairs and biometric screenings to events such as gratitude bingo and tai chi over lunch.

Virtual Support Groups

Virtual support groups have been the most successful effort for the SDPBC wellness program, Fabrikant said. The district has virtual groups that focus on a wide range of top-

ics or shared interests. For example, members of a pet lovers group share pictures and discuss their pets, and the district finds discounted pet services for them.

The SDPBC offered a virtual menopause support group during the 2024-25 school year that attracted 800 employees. The wellness program staff posted information such as workshops and community events, tips, motivating quotes and more. Group members received notifications of new information that they could check out when they had time.

For the 2025-26 school year, SDPBC will create a similar group called Aches and Pains that will focus on musculoskeletal issues and help make employees aware of all the district's resources.

Incentivizing Telemedicine

Free telemedicine has been the most successful wellness offering provided by the Georgia Bankers Association Insurance Trust (GBAIT), a multiple employer welfare arrangement (MEWA) that covers 15,000 participants and beneficiaries at member banking institutions. (Those enrolled in the association's high-deductible health plan (HDHP) are charged a copay for telemedicine visits.)

The trust partners with a wellness vendor to provide services that include telemedicine; virtual coaching; and services addressing mental health, nutrition, diabetes and more.

"Our mental health treatment and health coaching has exploded the past two years."

Keri Brooks
Chief Legal Officer
Georgia Bankers Association Insurance Trust
Atlanta, Georgia

The GBAIT has partnered with the wellness vendor since 2015 but began promoting free telemedicine services in 2017 to encourage people to try virtual care first before pursuing other higher cost options, such as the emergency room or urgent care. "Most of the time it saves money for the plan and saves them money too," said Keri Brooks, the association's chief legal officer.

Plan participants also have access to free virtual counseling if they access the benefit through the wellness provider.

TABLE I

Top Five Wellness Program Barriers*

Difficult for workers to find enough time to participate	33%
Prohibitive costs	32%
Lack of interest by workers	26%
Difficult to keep momentum going	24%
Lack of dedicated wellness budget	21%

*Respondents were asked to select all that apply.

This year, dependents ages 13-18 started also receiving the free counseling benefit, which has filled a need because the plan serves members across the state who may live in areas without providers who specialize in adolescent mental health.

Activity Challenge

A three-week activity challenge in which teams compete to accumulate the most steps is the most successful wellness initiative for Hubbard Broadcasting, Inc. The St. Paul, Minnesota-based company has about 2,000 employees at roughly 50 media stations in over 20 U.S. cities. Last year, 195 people signed up for the program, which has become a highly anticipated annual event, said Angela Subera, CEBS, the company's benefits manager.

Teams with names like School of Walk, The Pacemakers and Red Hot Chili Steppers vie for bragging rights in the activity challenge. Subera uses a third-party app to run the program, which is inexpensive and makes it simple for all locations to participate. Subera considers the program successful because of "the engagement and getting people excited about it. And we hear personal stories: 'This helped me kick off my weight loss,' or 'It helped me get outside more and be a part of my team.'"

Barriers to Success

In the survey, organizations identified roughly 30 barriers they face in offering wellness programs. Approximately one in three mentioned difficulties for workers to find enough time to participate or prohibitive costs. About one in four mentioned lack of interest by workers or difficulty keeping momentum going. One in five cited the lack of a dedicated wellness budget or privacy concerns among workers as barriers (Table I).

Subera stressed that wellness activities can be successful even with a low budget, and she encouraged employers to keep trying even if an effort fails.

Offering virtual programs has helped remove some of the barriers for the SDPBC, Fabrikant said. "It's been extremely beneficial, and we've saved money and we've saved time. We're just more efficient in our work. It's increased our engagement tremendously. Before, if I did a program and got 50 to 100 people, that was great. Now I have 800 people."

The International Foundation report showed that 28% of respondents have leaders who actively participate in initiatives, and 19% have leaders who act as role models for prioritizing health and work–life balance. However, 19% said leadership is not aligned with the organization's wellness initiative, and 18% said leaders do not participate in the wellness initiatives.

"Sometimes you just have to try things and see what sticks. We tried a challenge that wasn't very successful. It just didn't get the engagement. It wasn't the right moment. You have to be willing to try something different."

Angela Subera, CEBS
Benefits Manager
Hubbard Broadcasting, Inc.
St. Paul, Minnesota

Gaining leadership buy-in can be a challenge for wellness programs, wellness leaders said. Brooks mentioned that some employers in the GBAIT plan don't use the wellness services, despite the association's promotional efforts. Some of the small banks have just a handful of employees who may not have the time to promote the service. "They feel it's another thing they have to learn about and another thing they have to do," she said.

Measuring Success

The International Foundation report showed that only a small percentage (14%) of organizations measure the return on investment (ROI) for their wellness programs. However, organizations use other metrics to evaluate their wellness activities as represented in Table II.

TABLE II

Data/Metrics Used to Track Wellness-Related Activities*

Attendance and/or participation in wellness events	40%
Reports from health insurance company	32%
Reports from wellness vendor/company	31%
Worker surveys	21%
Database for workers to track wellness activities/participation	12%
Gamification incorporated into programs/initiatives	11%
Fitness tracker/app data	8%
Other	1%

*Respondents were asked to select all that apply.

Twenty-one percent of organizations do not collect information on wellness activities and participation.

At the SDPBC, participants must complete a survey following each event, which helps staff evaluate the effectiveness of programming. "We get 1,000 of those surveys each year to evaluate if we are doing the right thing," Fabrikant noted.

The GBAIT looks at data, including urgent care and emergency room expenses, to evaluate program success as well as telemedicine surveys, which reveal where patients would have gone for care if they didn't have access to telemedicine. The GBAIT estimates that it saved $644,873 from January 1, 2023 through December 31, 2024 from the diversion of in-person care to telemedicine services.

About the Report

Workplace Wellness and Financial Education: 2025 Survey Report includes responses from 331 corporations/single employer plans, multiemployer funds and public employer plans in the United States. To download the report, visit www.ifebp.org/workplacewellness25.

what's working | helping the adults in the room

Diamond Howell, Ed.D.
Staff Health and Wellness Manager, Phoenix Union High School District, Phoenix, Arizona

Erika Collins-Frazier, Ed.D.
Staff Health and Wellness Clinician, Phoenix Union High School District, Phoenix, Arizona

by | **Kathy Bergstrom, CEBS**

Getting help for a mental health issue is as easy as making a phone call or scanning a QR code for the staff at Phoenix Union High School District.

The school district, which operates a portfolio of 23 secondary schools in central and western Phoenix, Arizona and employs about 3,400 people, has found success in building staff resilience and well-being by hiring its own licensed mental health providers.

"We're changing the way people even consider getting help," said Diamond Howell, Ed.D., one of the district's two staff health and wellness managers. "We're trying to normalize the fact that you're not supposed to do it on your own, and you don't have to do it on your own."

COVID Takes a Toll

As the COVID-19 pandemic wore on in 2020, district leaders believed they had done a good job addressing the needs of students but recognized the toll the pandemic was taking on staff.

"We were coming back from the COVID school year, and we needed support, and we didn't know really what it looked like," Howell said.

The district decided to bolster its commitment to staff health and wellness and identified mental health as one of four pillars of wellness it wanted to focus on.

"They already had a wellness program that focused on the physical side of wellness," said Erika Collins-Frazier, Ed.D., a staff health and wellness clinician for the district. But beyond an employee assistance program (EAP), the district didn't have much support for mental health.

The district hired Collins-Frazier in early 2021 to start a mental health program for staff, which is part of the wellness program rebranded as PXYou. "One of the questions was how to provide mental health services quickly and efficiently to people who are at work all day and are in charge of kids: How are we going to effectively come in and help them regulate themselves when they're in the middle of doing these things?" she explained.

"One of the main things that we started was to reduce the stigma, which was really developing a campaign district-wide that was telling people it was OK to not be OK," Collins-Frazier said. "It was giving them permission to say, 'I'm falling apart, I need help, I'm struggling,' and then being there to help them get through that."

On-Site Counselors Improve Access

Another key initiative was hiring licensed counselors for the staff. The district now has three licensed professionals who work in school buildings, including Collins-Frazier; Cailene Pisciotta, a licensed counselor; and Jennifer J. Ramos, a licensed clinical social worker. The counselors have expertise not only in mental health but also community resources.

The program is advertised with traditional fliers and posters in addition to a virtual "road show" explaining the program that is shared with all of the school campuses. "You're not going to go very far before you run into our poster or our business card that has that little QR code on it," Collins-Frazier said.

When someone needs help, they can call or click on that QR code to send an email that goes into a secure inbox monitored by Collins-Frazier. She evaluates the request and emails the staff member to request a meeting.

One of the clinicians will meet with the individual on campus or wherever they'd like. "We have met at coffee shops, walking the track or in the parking lot in people's cars—wherever it is that they need to be to feel the most safe so that they can get help," she added.

And they have the knowledge that they can leave the classroom to talk to someone if needed and won't be penalized. Schools are willing to provide a substitute to run the classroom if a teacher needs time to talk.

District leaders understand that allowing a staff member time to decompress and refocus will improve the likelihood that they'll be back to work the next day and those to follow, Collins-Frazier explained. Otherwise, the district runs the risk of them "melting down" and not returning to work. "There's a definite benefit for the staff member right then and there, but there's also a benefit for Phoenix Union in the long run," she added.

"Our adults have to show up as their best selves in order to get our students to a place where they can show up as their best selves," Howell noted.

Issues may include work-related problems, student behaviors, divorce, abuse and homelessness in addition to mood disorders, which Collins-Frazier pointed out affect one in four people.

That initial visit is triage and involves mostly listening by the counselors. "Having somebody that you don't know who's trained to listen can really help you to come to terms or streamline in your mind what's actually bothering you so that you can come up with a plan and move forward in your day," Collins-Frazier explained.

Taking the Next Step

After the initial meeting with a counselor, the staff member decides the next steps. Many times, they want to see someone to continue with therapy because they've realized that asking for help isn't so scary.

"It feels a lot easier to connect with someone who's within the system because they understand what we're dealing with," Howell commented. "They can validate. They can understand. But then they also have all these resources. They have their own expertise and knowledge, but they can also help you get connected to additional resources."

The counselors simplify the process of finding a counselor by determining which in-network providers are accepting new patients and don't have wait lists. They then reach out to those counselors on the staff member's behalf, and those names are provided to the client.

In addition to therapy, the counselors also refer staff members to other resources, including the EAP or community resources, if they need help with other issues, such as legal problems or child or elder care.

The Phoenix Union High School District uses posters like these to encourage staff to reach out for help when they experience a mental health issue.

Other Services Support Mental Health

The PXYou program also provides other mental health services, including the following.

- **Crisis intervention:** If a crisis such as the death of a student or staff member occurs, counselors partner with the EAP to provide services including debriefing groups.

- **Group meetings and courses:** The counselors will meet with staff groups, such as individual departments, upon request to address issues like internal conflicts or stress. They will also schedule courses upon request covering topics such as resilience and thriving.
- **Monthly wellness webinars:** A mental health webinar called the Happy Hump Day Wellness Webinar is held on a Wednesday once a month for all staff to voluntarily attend.
- **Meditation with Diamond and Dan:** Howell and Dan Hull, a virtual instruction facilitator in the district, lead a mindfulness session at 9 a.m. on Thursday mornings on Microsoft Teams for education support professionals and certified and administrative staff. The district plans to expand the program for the upcoming school year.
- **Coaching services:** The district partners with a coaching agency to provide coaching for those who may find a bigger benefit from that over traditional therapy.

PXYou also has hosted other events, such as "Girl Talks," which was a virtual small group offering during Women's History Month in March that addressed topics such as miscarriage and menopause. Later in spring, the district held a social wellness activity called "Bloom Where You're Planted" to connect staff at the district office.

Collins-Frazier noted that staff members who aren't comfortable reaching out to the clinicians for their mental health needs can choose to find a therapist through Care Solace, a mental health coordination vendor.

Measuring Impact

Phoenix Union measures the impact of the program through the number of people who make contact but also conducts informal surveys.

"I measure success by the number of people who reach out to us," Collins-Frazier said, adding that a reduction in stigma is also an important metric. "To be in this position and see the number of people who voluntarily reach out for help and accept help—To me, that's a win."

Regardless of whether participants connect with a therapist or begin taking medication for anxiety or move forward with a divorce, "the fact that they said 'I need some help,' that's the win."

During the 2023-24 school year, 91 people reached out to the program. The number of initial contacts climbed to 127 through March of the 2024-25 school year. In addition, absenteeism has decreased.

Expanding the Program

One of the most significant changes since the program's inception was the hiring of Ramos, who is bilingual in English and Spanish. Collins-Frazier noted that English is not the first language of about 10-15% of staff. "I think if I would have changed anything, I probably would have pushed for bringing somebody who was bilingual on earlier than we did," she added.

She stressed that even though the district has had leadership changes, mental health has remained a priority. If contacts continue to climb, she predicted the district might look at hiring a fourth counselor.

Advice for Others

Collins-Frazier advised organizations that are considering a mental health program not to let funding concerns get in the way of those efforts. Sources of funding can include grants or partnering with a health insurer to provide counseling.

She also suggested that school districts in particular find counselors who are solely trained in mental health rather than coming from a school background. "They are going to be solely focused on what the staff needs—the adults in the room. We take pride in taking care of the adults in the room so that they can do their absolute best in taking care of our children."

heard on community | covering GLP-1 drugs

The costs of covering glucagon-like peptide-1 (GLP-1) drugs to treat weight loss continue to concern many employers and health plan sponsors. The topic of cost-management strategies for these drugs recently generated a lively discussion on Foundation Community.*

the question

> We use [our pharmacy benefit manager's] premier formulary which covers the new weight loss drugs with a copay. We spent $1 million in 2023 on the new weight loss drugs. It's a great benefit, but the cost is out of control. Is anyone else using a vendor to manage this? Any success with cost management?

the conversation

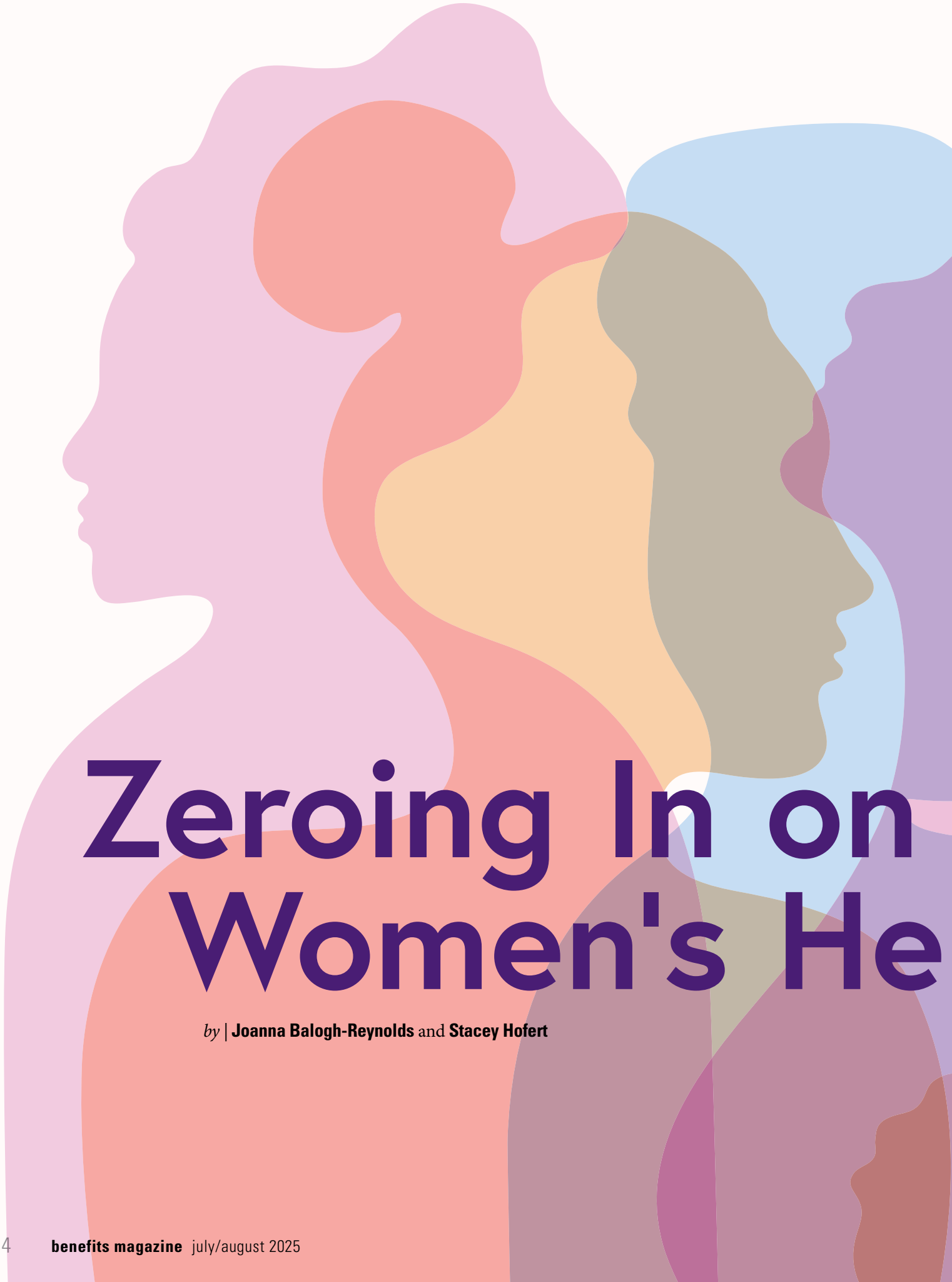
I am an insurance broker for self-funded groups and, due to the rising costs of GLP-1s, we carved it out for most of our clients and are using [a vendor] that is available through our captive or standalone for groups over 1,000 employees. Outside of the captive program and for smaller companies, we are using [a vendor]. Both of these programs charge per employee per month for their services and wrap a weight loss program around the program, which helps with more positive outcomes. [Another PBM] just rolled out a program that allows an employer to subsidize a portion of the reduced costs.

We are struggling with this as well. We are self-funded and currently exclude weight loss drugs. Additionally, there are prior authorizations put in place for people who are trying to use a GLP-1 (like Ozempic®) off-label.

As an alternative approach, some groups I work with are covering bariatric surgery at no cost to the member. That way you're avoiding some of the potential GLP-1 costs altogether. There are some initial studies suggesting that bariatric surgery is more effective for long-term, sustained weight loss than meds alone.

Are you looking for input from your peers on a benefits issue?
Visit community.ifebp.org to join a community and get talking.

*Comments may be edited for brevity and to meet *Benefits Magazine* editorial guidelines.



Zeroing In on Women's He

by | **Joanna Balogh-Reynolds** and **Stacey Hofert**

Multiemployer plans that prioritize women's health and family building may foster healthier, less stressed members and better outcomes, including healthier pregnancies, healthier babies and improved maternal health. Benefits to consider include family-building, maternal health and menopause programs.

The issues of women's health and medical benefits for women are gaining increased attention as organizations, including multiemployer health plans, recognize that focusing on these concerns could generate more favorable outcomes for women, their families and organizations.

Organizations and society as a whole are increasingly focused on driving change, not just for benefits, but on issues from pay gaps—women working full-time in the United States are still paid just 83 cents to every dollar earned by men[1]—to care gaps, including the frequent exclusion of women from clinical trials until 1993.

Gaps in care and an overall lack of support can have a direct impact on organizations' productivity and profitability. While women drive 80% of health spending decisions, prioritizing their own care has not always been their own focus, nor the focus of benefit plans.[2] Today, however, more multiemployer benefit plans may want to consider the impact of health care gaps on their female plan participants as well as trends in the labor market. The availability of women's health and family-building benefits has increased, helping organizations make positive strides in care gap closure, as well as in employee retention and recruiting.

Comprehensive benefits for women can enable improved well-being across health conditions and milestones of life. Investing in women and their health may lead to higher engagement in the workplace, more effective operations and strengthened families, creating a real opportunity to generate both economic and societal benefits.

Women in the Labor Market

The gender makeup of many industries is evolving. While women have primarily dominated the service industry—particularly education and health—they are increasingly entering nontraditional, male-dominated careers, including the trades and food/retail industries involving processing, packaging or manufacturing. The number of women working in trades occupations exceeded 314,000 in 2021, marking a nearly one-third increase over the previous five years.[3] On the building side, the Million Women in Construction initiative aims to double the number of women in construction—currently about one million—over the next decade.[4] New educational and training programs are serving to support women in helping to fill the high demand for jobs in the industry. The benefits environment likely should adjust to reflect these changes.

Further, there are simply more women in the workforce: Three-quarters of prime-age women (those age 25-54) have a job, compared with about two-thirds a decade ago.[5] They are working longer hours; 84% of employed, prime-age women work full-time. As the gender employment landscape continues to shift, organizations require guidance on how to support women in the workforce and solve their most pressing health care challenges. Addressing these challenges may result in lower costs, higher retention, less absenteeism and improved member satisfaction across organizations. Multiemployer plans that prioritize women's health also demonstrate a commitment to caring for members who often spend a lifetime caring for others.

Outcomes-Driven Support for Women

Women's health benefits provide support not only for managing chronic conditions and disease but also for many milestones throughout a woman's health journey and specifically during the traditional working years. These milestones include preconception, fertility and family building; pregnancy and postpartum; parenting and responsibility for child well-being; and menopause and midlife care. Each experience can benefit from tailored approaches, delivered by specialty providers trained to care for unique symptoms and health needs. Unfortunately, many women have health concerns that go unaddressed due to their primary care physician or obstetrician/gynecologist (OB/GYN) not having the expertise. This lack of specialization in care can lead to a compounding of untreated issues and high costs later in life. Organizations that prioritize member education and care within their workforce can help reduce the risks of health complications along the complex health journey of womanhood.

Focusing on the outcomes—including a healthy pregnancy, healthy mother and baby, a successful return to work, and a positive experience during menopause—can be a good framework for organizations in implementing a comprehensive benefits plan that looks at the complete health journey.

takeaways

- Comprehensive benefits for women can enable improved well-being across health conditions and milestones of life. Investing in women and their health may also lead to higher engagement in the workplace, more effective operations and strengthening of families.
- The employee benefits environment should adjust to reflect changes to the labor market: The number of women working in trades occupations exceeded 314,000 in 2021, marking a nearly one-third increase over the previous five years.
- Women's health benefits provide support not only for managing chronic conditions and disease but also for many milestones throughout a woman's health journey, including preconception, fertility and family building; pregnancy and postpartum; parenting and responsibility for child well-being; and menopause and midlife care.
- Benefits that support pregnancy and maternal health include fertility benefits that provide access to the latest reproductive technologies, a large network of fertility specialists and current available treatments. Benefits also can provide guidance about prenatal nutrition and lifestyle behaviors as well as management of chronic conditions and mental health needs during the fertility and pregnancy journeys.
- Menopause benefits, including access to certified experts in menopause, support plan participants by helping them experience better health and wellness while staying present and productive at work.

Pregnancy and Maternal Health

Pregnancy is one of the first reproductive milestones among working women.

Fertility and family-building solutions are one type of benefit that plan sponsors may want to consider. These programs may be offered through a specialty vendor or through programs offered by a health insurance company. Fertility and family-building benefits

support members in achieving pregnancy, maintaining good health throughout the pregnancy and delivering a healthy baby.

Without such programs, women may experience barriers to care, such as lack of coverage, limited coverage and limited access to specialty-trained providers. A comprehensive benefits plan ensures that women and families are connected with quality providers and treatment options to support their family-building goals. Further, care along the journey supports optimal maternal health. For instance, recommendations about prenatal and maternal nutrition and lifestyle behaviors as well as management of chronic conditions and mental health needs during the fertility and pregnancy journeys support improved outcomes. Gestational diabetes, for instance, affects up to 9% of pregnancies in the U.S. each year,[6] and mental health conditions affect 20% of pregnant and postpartum women.[7]

By providing access to multidisciplinary providers, a comprehensive fertility and women's health benefit offers care, support and critical advocacy. Plans may want to look for benefits that cover specialty-trained providers, including labor and delivery nurses, certified doulas, pelvic floor specialists, clinical social workers, therapists and lactation consultants. These specialists may also support women who experience miscarriage or preterm birth or who have babies requiring neonatal intensive care unit (NICU) stays.

As the employment landscape continues to shift to include more women, organizations that provide more support for plan participants throughout their journey will likely be more successful in recruiting and retaining women—and men. In particular, parents say a lack of support during pregnancy and maternity—as well as child-care difficulties—are the most important reasons for considering leaving the trades.[8]

The postpartum period can be a trying time for new mothers as they adjust to caregiving while recovering from birth. They benefit from receiving regular check-ins from doulas and other providers for support, as well as educational resources about newborn care and feeding. A healthy postpartum experience enabled by quality health care plans typically leads to a positive transition back into the workplace.

Return-to-Work and Family Resources

Organizations are recognizing the value of supporting parents, which can benefit both women and men. Nearly 40% of the U.S. workforce consists of parents with children under 18, and 48% of those parents say that their stress is overwhelming on most days.[9]

Overall, the challenges of parenting—physical, emotional, mental—are ever-present and can greatly impact productivity and quality of life. A barrage of conflicting parenting advice from various sources can feel overwhelming, both as it relates to big-picture viewpoints and seemingly mundane, daily decisions.

The Impact of Doula Support

Pregnancy, childbirth and perinatal conditions currently represent one of the largest shares of employer health spend* in the U.S. Adding coverage for in-person and virtual doula services furthers the ability of plan sponsors to provide equitable, high-quality care that can improve outcomes across a diverse member population.

Doulas can play a critical role in providing women with evidence-based guidance and advocacy along the pregnancy journey, such as helping reduce cesarean section rates and NICU complications such as low-birthweight babies, which lowers downstream costs. They also help reduce maternal health barriers by providing evidence-based source material to educate women about maternal health and empower them to communicate with care providers about their unique health needs before, during and after their birth experience. Doulas are associated with four times lower likelihood of having a low-birthweight baby and two times lower likelihood of a birth complication.**

Doulas are often vital in facilitating culturally competent care and improving maternal health outcomes, especially for minority women. The maternal mortality rate for Black women is 2.6 times the rate for white women and more than double the national average.† Plans may want to look at their benefits to ensure that they are reflective of their workforce's needs.

*National Alliance of Healthcare Purchasing Coalitions. "High-Cost Claims."

**K. J. Gruber, S. H. Cupito and C. F. Dobson. "Impact of Doulas on Healthy Birth Outcomes." *Journal of Perinatal Education.* 2013 Winter;22(1):49-58.

†*Maternal Mortality Rates in the United States, 2021.* Centers for Disease Control and Prevention (CDC) National Centers for Health Statistics.

Multiemployer plans that embrace a family-focused benefits approach can create an environment that fosters healthier, less stressed members and better outcomes for both parents and children. High-touch, holistic support, including the programs described below, for working parents and caregivers encompasses lasting solutions for return-to-work challenges, ongoing emotional health support and comprehensive benefits navigation.

Taft-Hartley plans have an opportunity to prioritize both the mental and emotional health of members and the experiences surrounding the development of their children. By providing families with information and guidance, parents can return to work from leave, prepared with a plan that allows full engagement with their child-care and wellness benefits and satisfaction in their roles. This may include personalized support in the form of one-on-one guidance on benefits navigation, which can address issues such as adding a new family member to the plan, available benefits and provider care access. Further, tips for work–life balance and child rearing; digital tools and resources such as support groups; transitional tools such as a flexible schedule (if feasible); space and time to express breastmilk (if desired); and frequent manager–employee check-ins can help reduce absenteeism and improve retention.

These services could be provided by the human resources departments of contributing employers as well as employee assistance programs (EAPs), but many plan sponsors can also work with specialty vendors to provide these services. To best support mothers and families, plan sponsors should look for those that offer integrated services across the spectrum of needs, streamlining care with one point of integrated access versus a different benefit contact for each service. These benefits can further enable women and their partners to more fully step back into their workplace role.

One of the primary concerns of women returning to work remains securing child care. Among parents with children under 18 who seriously considered leaving their trade altogether, 69.3% have had difficulties finding child care.[10] To ease this burden, organizations can provide guidance on financial planning, reduced-cost child care or other support options. One local of the United Food and Commercial Workers International Union (UFCW), for example, helps women navigate and budget for child care, offering a child-care grant to offset costs for members.[11]

Benefits Through Menopause

Once a taboo topic, menopause—a reproductive stage that can bring hot flashes, fatigue, poor concentration and other disruptive symptoms—is now becoming part of a regular conversation, in part because celebrities have brought attention to the discussion by sharing their stories publicly. The idea that menopause is a medical condition best met with specialized care has gained broader acceptance. It is a significant life stage that has long been overlooked in the workplace, despite its impact on physical health, mental well-being and professional success. In a survey of female employees, 59% took time off work due to menopause symptoms.[12] A separate study reported that one in four women in leadership positions felt that their menopause symptoms negatively impacted their career development or work-related opportunities, while 17% have actually quit a job or considered quitting due to menopause symptoms.[13] More than half of respondents (57%) said that it would be important to them if a potential employer clearly expressed a commitment to support employees with menopause symptoms.[14]

As women become more mindful about how menopause affects their performance at work, unfortunately their concerns may be unaddressed by general health care providers. Only about 30% of OB/GYNs receive any menopause training during residency, and the percentage of primary care physicians with the training is even lower.[15] Certified experts in menopause support plan participants by helping them experience better health and wellness while staying present and productive at work. Particularly when the workplace requires physical labor or is a male-dominated field, there is greater need for increased awareness, education and advocacy.

With about half of the U.S. workforce experiencing menopause symptoms at some point in their careers, organizations can guide plan participants toward better health and wellness to stay present and productive in the workplace. Seventy-three percent of women in varying stages of the menopause journey are experiencing the

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Education

Menopause in the Workplace: An Emerging Wellness Practice On-Demand Webcast
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effects of menopause but not seeking proper treatment to manage them.[16]

Plans may want to consider adding a benefit that addresses current gaps in care and provides access to support from specialty-trained providers who create individualized care plans based on symptoms, medical history, and goals for work and life. As previously noted, these types of benefits may be available through a program offered by a health plan or a specialty vendor. Plan sponsors should inquire about the specialty education of the providers and the types of coverage available. Plan participants can benefit from health coaching and guidance from licensed health professionals on nutrition and weight management, sleep issues and mental health, among other health problems. Although there are smartphone applications now available to help women track and manage symptoms, when a benefit is provided with a personalized relationship for the journey, the longer term relationship may better support the individualized health needs of the member.

A Focus on Women's Health for Lasting Value

The complex clinical, emotional and practical needs of women's health demand comprehensive support in the workplace. By providing personalized, proactive care from preconception through menopause, organizations can foster a culture of health and well-being, improving outcomes and reducing health care costs overall. As women reach pivotal milestones, Taft-Hartley plans can close current gaps in care by partnering with benefits providers that truly advocate for them.

In a recent study, nearly 70% of benefits decision makers recognize the importance of providing comprehensive health benefits that specifically target women to attract and retain top talent.[17] The survey revealed that organizations are looking for health care and benefit experts to help them shape resources where there are gaps in offerings. These types of forward-thinking organizations can potentially facilitate a brighter future for women—in management of their personal health, in the workplace, at home and beyond.

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bios

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The increase in the number and sophistication of cyberattacks has made it increasingly difficult to protect employee benefit plan member data. Artificial intelligence (AI) holds promise for better data security while improving members' experience.

Securing Member Data With the Help of AI

by | **Laurent Laor**

Imagine opening your mailbox to find a letter confirming your worst fears: Your Social Security number, medical history and financial data are now in the hands of unknown criminals. That's exactly the situation I faced in mid-2024, when I came across alarming news of a massive data leak at a national background check provider. The breach exposed the personal details of millions, even billions of people. That made me wonder: Is my information floating out there, too?

With growing unease, I searched for my own records in the aftermath of this breach. Sure enough, I found traces of my personal data in places it absolutely didn't belong. Not long after, my fears were confirmed by an official letter from a health care processing company in September 2024 notifying me that my protected health information (PHI) had been compromised. This breach ultimately exposed the PHI of over 100 million people, roughly one-third of the U.S. population. Realizing that my Social Security number, contact info and even medical details were now in unknown hands was a personal wake-up call. It sparked a sense of urgency—and frankly anger—to bolster my security measures immediately.

Knowing that my own data was swept up in such a breach made the threat intensely real. I took steps including monitoring my credit and freezing accounts, but I also started thinking bigger: How do we prevent this kind of exposure in the first place? As someone involved in managing benefits for labor union members, I especially worried about how well benefit funds are protecting personal member data and whether security measures might be overdue for an upgrade.

Security vs. Usability: Lessons From a Health Fair

Around that time, a candid conversation at a union health fair drove home another critical point. I spoke with several members about how they access their benefits information online. One older retiree admitted that he avoids the benefits app whenever possible because he dreads the hassle of resetting a forgotten password. Another member joked that logging in to check his health fund status feels like trying to break into Fort Knox, given all the security hoops to jump through. Their frustration was palpable.

This highlighted a key dilemma that benefit plans face: They need strong security to protect sensitive health and pension data, but if the process is too cumbersome, people either won't use it or will find risky work-arounds. At the health fair, I saw usability challenges up close. Plan members want simplicity. They don't want to remember complex passwords or carry security tokens just to get their work and health information. Yet, after my breach scare, I knew that security shouldn't be taken lightly. How can benefit plans strike a balance where plan member data stays safe and members can easily access their benefits?

AI-Driven Authentication: A Potential Game Changer

The answer to this security-versus-usability puzzle may lie in next-generation, AI-powered authentication. Imagine if signing up for a benefits app was as simple as taking a photo of your ID and snapping a selfie and, from that point on, logging in was nearly instant with just your face or fingerprint. It sounds futuristic, but these technologies are available today and could revolutionize how members interact with their benefits. Here's one three-step approach that is being used by several identity management software providers.

1. **ID scan and verification:** Instead of forcing a new user to create passwords and security questions, the user scans their government-issued photo ID (such as a driver's license) using a phone or webcam. Advanced software, backed by AI, instantly checks the ID's authenticity—confirming that the document is valid and not a forgery. The system automatically reads the necessary details (name, date of birth, etc.) from the ID, reducing manual data entry. This step establishes a foundation of trust by tying the account to a verified, real-world identity.
2. **Liveness selfie check:** Next comes a quick selfie, but with an important twist: The user is prompted to take a live selfie (often blinking or turning their head as instructed). The AI system analyzes the selfie and matches it against the photo ID image to ensure that the person is the same individual and is physically present. This liveness detection prevents someone from using a stolen ID or a static photo to impersonate the member. It's even sophisticated enough to thwart deepfakes—an increasingly common fraud tactic. Criminals have started using AI "deepfake" videos and images to spoof identities, with such attacks rising 31-fold from 2022 to 2023.[1] By analyzing subtle cues including skin texture, shadows and motion, the system can tell a genuine live person apart from a fake, catching inconsistencies that a human eye might miss. This step adds a powerful proof: You are who you claim to be.
3. **Secure biometric log-in:** Once the ID and selfie are verified, the member's account is officially confirmed. Now they can dispense with passwords altogether. The user sets up a biometric log-in method for future access, typically using their smartphone's built-in fingerprint or facial recognition. From then on, logging in is as easy as a touch or glance. No more passwords to remember or reset. This isn't uncharted territory; the federal Thrift Savings Plan (TSP) rolled out fingerprint and face log-in for its users in 2024, touting that you can now log in "quickly and securely" with biometrics.

takeaways

- Employee benefit plans have a responsibility to protect plan member data but also need to find ways to make it convenient for members to access benefit services.
- Authentication methods powered by artificial intelligence (AI) may be a big part of the solution.
- One process being used by identity management software providers allows members to scan and authenticate their identification, take a live selfie and create a secure biometric log-in.
- AI verification can spot forged IDs or falsified documents by detecting anomalies that a human might miss and can greatly reduce the risk of account takeovers.
- Plans should make sure that identity verification vendors adhere to Health Insurance Portability and Accountability Act (HIPAA) standards as well as the National Institute of Standards and Technology (NIST) guidelines on digital identity to ensure that they are following best practices.

For multiemployer plan participants, it means that accessing their health or pension info could be as straightforward as unlocking their phone, but with security that meets high standards.

Integrating these steps creates a streamlined yet high-security log-in flow. The first two steps (ID plus selfie) happen just once during enrollment, establishing a trusted identity for the individual. It's a bit like a digital "notary" process—The system has proof of who you are. After that, every log-in is low-effort. The biometric check confirms it's still you, without any typing or codes. From a user's perspective, it's convenient and quick. From a security perspective, it's light years ahead of the old username-and-password approach.

Built to Thwart Modern Fraud and Protect Data

Crucially, this AI-driven authentication is not just convenient, it's designed to defeat modern fraud schemes and protect sensitive data in line with strict regulations. The AI verification can spot forged IDs or doctored documents by detecting anomalies that a human might miss. The selfie liveness check, as mentioned, helps ensure that nobody is duping the system with a picture of someone else or an AI-generated fake. These measures should greatly reduce the risk of account takeovers because an attacker would need to possess an exact match of the victim's physical identity, which is a far taller order than simply stealing a password.

From a fraud-prevention standpoint, this approach closes many of the gaps that hackers and identity thieves have exploited in the past. Weak or reused passwords? No longer an issue. Phishing attacks to trick users out of credentials? A phony email can't steal your face. Social engineering won't easily bypass a live biometric check. And those knowledge-based security questions (like your mother's maiden name or first car) that hackers often glean from public data become obsolete. By leveraging something you have (your government ID) and something you are (your biometric traits) instead of just something you know (a password), vendors adhere to a true multifactor authentication model that is inherently more secure.

Any system that stores plan member data must treat privacy and compliance as nonnegotiables—especially when that data includes medical details. Health plan vendors are legally bound by the Health Insurance Portability and Accountability Act (HIPAA) and similar regulations to safeguard protected health information (PHI); the best go further, aligning their security programs with gold-standard frameworks, such as the National Institute of Standards and Technology (NIST) Digital Identity Guidelines (SP 800-63).

In practice, every piece of personal data—photo IDs, biometric templates, you name it—should be encrypted and managed under strict data-protection rules. The goal is to strengthen security without sacrificing privacy. Take biometric log-ins: They can be designed so the fingerprint or

Setting Up and Using AI Authentication Systems

Employee benefit plan sponsors may want to consider the following when pursuing an authentication system driven by artificial intelligence (AI).

- Look for systems that incorporate government-issued identification and liveness detection to reduce the chances that someone will use a stolen ID or photo to impersonate a member.
- Consider systems that also create a more user-friendly experience for members, such as allowing them to use their smartphone fingerprint or facial recognition to access the system once they've set up their log-in information.
- Ensure that systems have strong encryption protocols and secure storage practices for member data.
- Confirm that the system adheres to health care security regulations, such as the Health Insurance Portability and Accountability Act (HIPAA), which mandate protecting patients' health data.
- Find out whether vendors follow industry standards, such as National Institute of Standards and Technology (NIST) guidelines on digital identity, to ensure that they're following best practices.
- Inform plan members of how the plan will collect, use and retain their personal information.
- Conduct periodic security audits.

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facial scan never leaves the user's device or, if stored, remains in an encrypted form that even system administrators can't decrypt, sharply reducing the risk of exposure.

NIST's *Digital Identity Guidelines* place their highest assurance on a two-step test: Validate a government ID, then match it to a live biometric scan. Solid encryption and secure storage are essential, but transparency matters just as much. The Identity Management Institute advises any group using biometrics to spell out—in plain language—what data is taken, why it's needed, how long it stays and when it disappears. Just as crucial, independent security audits should be scheduled regularly to verify that these promises still hold.

Adopting biometric authentication directly addresses common plan member frustrations—including cumbersome password resets and complicated log-in processes—enhancing both security and ease of use. By embracing advanced biometrics, vendors can deliver the seamless, secure access that members deserve, reinforcing their trust in how benefits administrators protect their most sensitive information.

Real-World Success: IRS and ID.me

The value of AI-driven biometric authentication is being proven in practice. The Internal Revenue Service (IRS) now partners with a digital identity management solution provider, ID.me, to secure taxpayer accounts. Taxpayers accessing IRS systems are asked to verify their identities simply by uploading a government-issued ID and taking a quick selfie, which the system checks using AI-powered liveness detection to ensure authenticity. This approach emerged out of necessity during the COVID-19 pandemic, amid rising identity theft and fraud targeting government benefits.

IRS officials noted that this approach nearly doubled the success rate of identity verification compared with previous methods. By 2024, more than 130 million people in the United States had been enrolled, significantly cutting fraud—Seven states alone credited use of the verification system with preventing more than $270 billion in fraudulent claims.[2] Such results underscore the practical benefits of upgrading security measures to sensitive information such as employee benefits, demonstrating that robust protection and user-friendly access don't have to be mutually exclusive.

A Safer, Simpler Future for Plan Members

Turning my personal data breach scare into action, I've come to appreciate that modernizing authentication is not only about shielding data from bad actors. It's also about making sure the plan members can get in without headache. In the employee benefits world, especially for plan members who may not be tech-savvy, ease of use is a security feature in itself. If the secure way is also the easy way, people are far more likely to adopt it and stop avoiding or undermining the safeguards.

Pairing AI-based identity proofing with biometric sign-in lets benefit funds harden security and simplify access in one move. The portal opens only after a live fingerprint or face scan matches a verified ID, blocking credential thieves while sparing members the password hassle. The result is a quicker log-in, fewer reset tickets and a dramatic drop in the odds that sensitive benefit data ever leaks.

In the wake of the previously mentioned data breach, it became clear that benefits administrators can't be complacent. Once public, your information is out there for everyone to see, and no one understands that better than those of us who have found our data on the wrong side of a breach. We can't undo those incidents, but we can learn from them. For employee benefit plans, that means proactively embracing stronger authentication methods now—before the next big attack—and staying one step ahead of criminals.

bio

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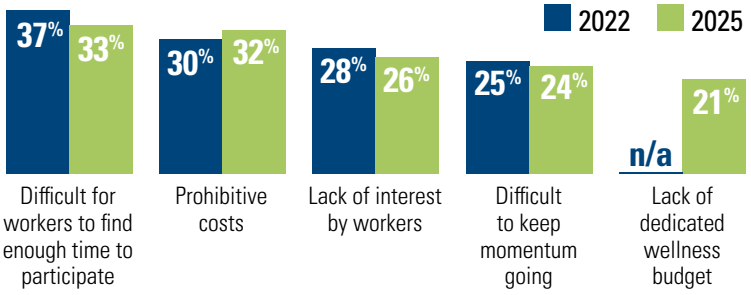
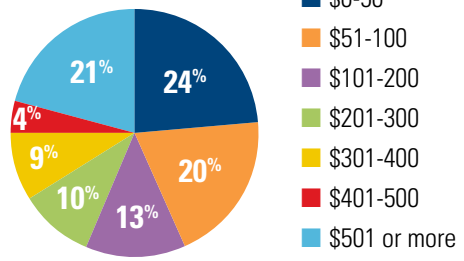
quick look | workplace wellness and financial education

More than six in ten (62%) organizations offer wellness initiatives to improve overall worker health and well-being, while 28% cite controlling or reducing health-related costs as their top goal and another 10% seek to improve retention and recruitment. Those are among the findings in *Workplace Wellness and Financial Education: 2025 Survey Report*, a recent report from the International Foundation of Employee Benefit Plans. The survey received responses from 331 corporations, multiemployer funds and public employers in the United States and is available at www.ifebp.org/workplacewellness25. Following are some survey report highlights.

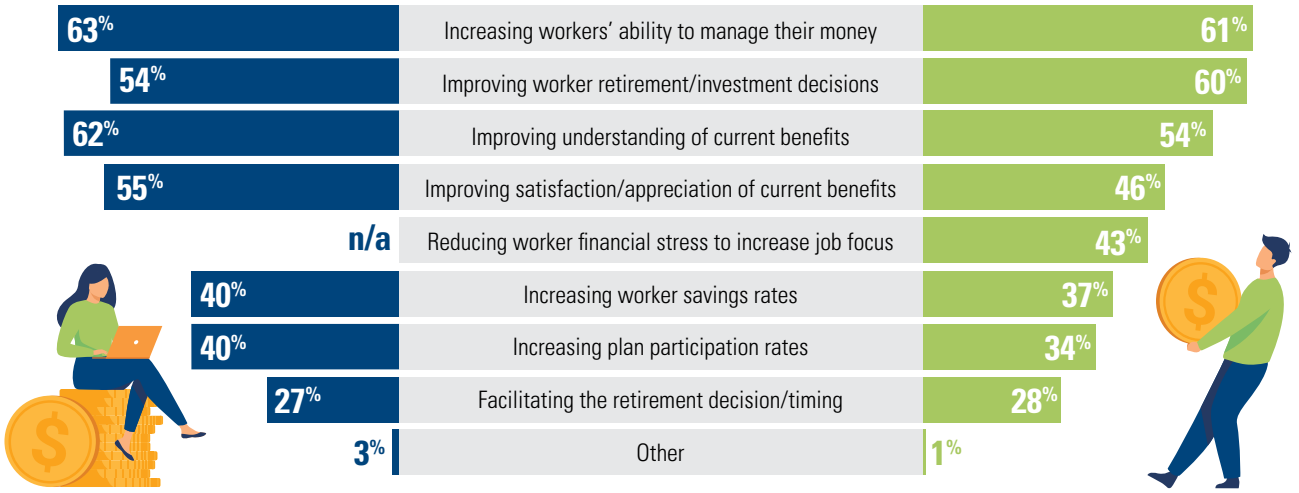
Wellness Initiative Barriers



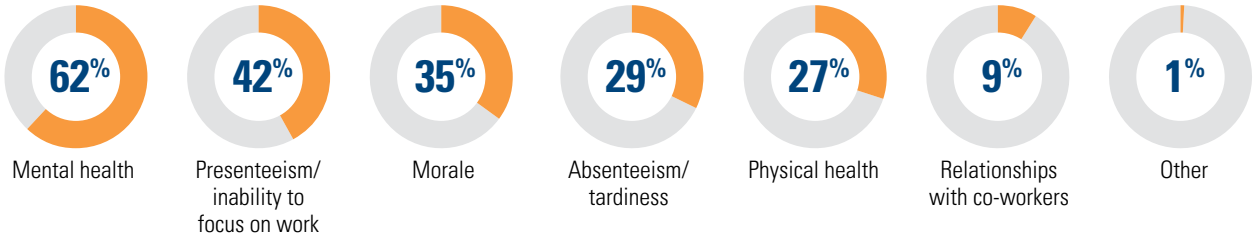
Wellness Initiative Budget (per worker per year)



Primary Goals of Pension and Benefit Education Initiatives



Performance Issues Impacted by Worker Economic Challenges

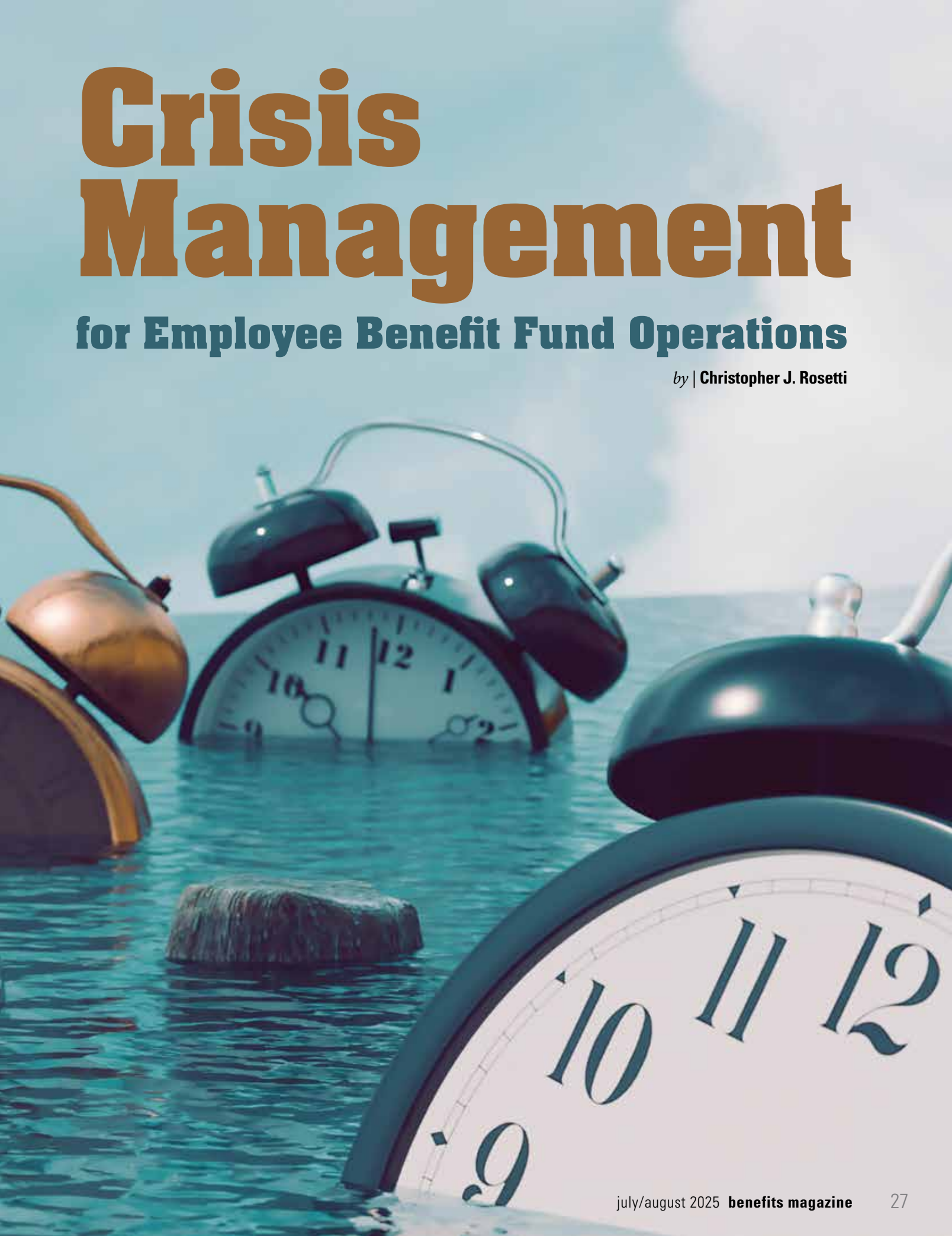


A crisis can occur at any time, without warning and with potentially serious consequences, especially if you are unprepared. Fortunately, proper planning can help your employee benefit plan ameliorate the impacts of these events.

Crisis Management

for Employee Benefit Fund Operations

by | **Christopher J. Rosetti**



During my formative years, my parents frequently told me that sometimes it is best to make a mistake when you are young because you're more inclined to learn from it and, therefore, you tend not to repeat your mistakes.

Well, I made many mistakes and took that wisdom to heart in both my personal and professional endeavors. I shared this lesson recently during presentations I made with a colleague on crisis management for the International Foundation of Employee Benefit Plans.

The crux of the presentation was that it's hard to mitigate a crisis if you don't consider the likelihood of its occurrence—and plan for its possibility. While I don't know this for certain, it's my guess that several organizations didn't have a plan or expect the wide-ranging impact of the fires that ravaged the southern California coastline earlier this year. Furthermore, and based on what I've read, I'm sure many organizations were affected by the epic devastation caused by Hurricane Helene in 2024 as it ransacked communities across the Southeast after its sojourn from the Gulf Coast.

My parents' advice can serve as a lesson in this instance: My hope is that those disaster-affected organizations that didn't have crisis management plans have learned from their experiences and will make sure that they are ready to respond to future disasters.

Costly Disasters

The number of weather and climate disasters causing at least $1 billion in damages climbed to a record level of 28 in 2023.[1] In addition, over the past five years, the number of billion-dollar disasters has averaged 18 annually.[2]

takeaways

- It's difficult to plan for a crisis if you don't know your plan's vulnerabilities.
- Don't reinvent the wheel—Interact with other plan sponsors and learn from their experiences when planning for a crisis.
- Review your insurance policies and evaluate your coverage relating to cybersecurity issues and natural disasters.
- Consider the likelihood of climate-related issues specific to your area and develop a remediation plan in the event of its occurrence.

The dollar amounts notwithstanding, some of the organizations impacted by these disasters suffered significant loss of electronic and other data, which oftentimes paralyzed their operations. Some of these companies never reopened.

Considering this, it likely isn't a question of whether your organization will be impacted by a crisis—but when it will happen.

The reality is that natural disasters (hurricanes, tornados, earthquakes, floods, landslides, etc.) increased by a factor of five between 1970 and 2019.[3] It may be hard to pick a state that is not affected by natural disasters. Texas and California had more than 20,000 wildfires during 2022; Mississippi had approximately 184 tornadoes that year, and the state of Washington had approximately 500 floods in the same year. Florida also led with the most hurricanes, and Illinois was second most at risk for billion-dollar climate disasters.[4, 5]

Given the above, it's incumbent for any pension/welfare benefit fund office to plan for the possibility of these events, not only because they happen, but also because it is your responsibility, and your members are depending on their pensions and health and welfare benefits.[6]

Natural disasters and weather events are not the only risk to benefit plans. Hacking or other cybersecurity events can also be disastrous. For example, 63% of all respondents replying to a survey question during our presentation acknowledged that a cyberattack/hack was the most likely crisis that would impact their pension/welfare fund in the next two years.

Plan sponsors also may be challenged by economic uncertainty, workforce shortages, energy consumption changes, and updates in legislation and regulations.

Fiduciary Duties

It's imperative to remember that all plan sponsors are subject to fiduciary responsibilities under the Employee Retirement Income Security Act (ERISA), including but not limited to the following.

- **Duty of care:** Acting in a prudent manner
- **Duty of loyalty:** Acting in the best interest of the beneficiaries
- **Duty of prudence:** Making decisions concerning the interests of the beneficiaries

Accordingly, your plan should periodically consider the possibility and probability of natural (geologic, clima-

Frequency of Disasters

During our presentation at the Advanced Trustees and Administrators Institute conference in 2024, my colleague and I polled the audience and asked whether their pension/welfare plan had endured a disaster within the past five years. Many audience participants responded yes, and that's not surprising when you consider the number of business continuity issues and disasters that have occurred within the past five years, including but not limited to the following.

The COVID-19 pandemic

The 2021 winter storm in Texas, during which millions of people lost power

Hurricane Ian, which caused $112.9 billion in damages

2023 wildfires in Hawai'i

2024 flooding in Alaska

2024 storms in Illinois

tological, biological) and man-made disasters (terrorism, pollution, nuclear accidents, civil unrest, ransomware, power outages) since any one of these could result in challenges for your organization or business partners. For example, if a crisis affects a vendor that supplies your fund office with items such as paper, toner, etc., you may need an alternate source of these materials to continue sending pension checks, statutory notices and other required documents.

Regardless of the type of disaster, almost every entity faces the same immediate issues when it has experienced one. For example, organizations may need to:

- Restore computer operations
- Find temporary work locations
- Have a method for communicating with staff, participants and business partners
- Retain staff.

Putting Together a Plan

Transitions can not be effectuated without proper planning—Preparation is key.

Risk Assessment

The first step should be conducting a formal risk assessment that considers unexpected occurrences. The risk assessment should evaluate the probability of an event occurring, your vulnerabilities and the potential cost associated with an event. Focus on the areas that result in the greatest costs, such as cyber intrusions, data breaches and theft of organizational assets.

Steps in this process include the following.

- **Set clear objectives.** Establish a deadline and to whom the assessment should be presented.
- **Review insurance policies.** Review your cyber, business owners' and umbrella policies to see what risk, if any, can be potentially assumed by others.
- **Seek assistance from experts.** These might include the plan attorney, insurance broker, mitigation specialists and IT consultants.
- **Gather feedback from staff.** This would include IT, accounting and human resources staff who may have solutions or may be aware of other matters that management hasn't considered.
- **Identify available resources.** It also doesn't hurt to reach out to others and learn what they experienced during a crisis, since these organizations are likely to have some practical advice.

Crisis Management

After assessing the risks, the plan should cover how a crisis will be managed. Essential elements of crisis management include the following steps.

- **Identify internal hazards and risks.** It is often helpful to consult with other plans to see what they have experienced and how they resolved the issues.
- **Communicate risks.** Periodically remind staff of the risks, specifically cyber-risks and the red flags of fraud, and how they can be avoided. Prudent practices dictate sharing knowledge and information with your staff so that they are aware of current trends and schemes.

- **Mitigate consequences.** Assume, transfer or mitigate the risks once they have been identified. Most organizations transfer the risk by obtaining the required insurance, and others also mitigate these risks by implementing rigorous internal controls. Still, others assume these risks by self-insuring or taking the gamble that certain occurrences will never happen.
- **Restore trust.** Working with staff to reach a common goal instills a sense of pride between the team members and is instrumental during times of crisis as the plan members realize their benefits have been unaffected or timely restored.

Focus on Business Continuity and Recovery

Finally, your plan should address ensuring that the organization's operations can continue and recover after a crisis has occurred. Some of the key areas to address in business continuity include the following.

- **Communication:** Your plan needs to ensure that communications won't be interrupted. Using phone applications that can be downloaded on personal cell phones is one option since they generally aren't impacted by power outages (i.e., your cell phone can receive calls originally directed to your plan office phone system and your desk phone).[7] Make sure that the fund has current telephone numbers and email addresses in order to send emails or phone blasts. Consider providing an online Q&A if phone lines are down. Lastly, having a social media site can be instrumental in communicating messages to the masses in the event email capabilities have been compromised.
- **Continuity of power and access to information:** Many institutions that have been through these situations have lessened their risk of power interruption by leasing a generator as part of their facility rental agreement, and/or they utilize off-site premises or a colocation for data storage. As such, they are almost always immune to some of the issues associated with disasters. During one recent International Foundation presentation, 100% of the attending participants who responded anonymously reported that their organization utilized a colocation for their electronic systems or had off-site storage of electronic information.
- **Access to equipment:** Another common recipe for survival is to have spare computer/phone equipment that can be used remotely if staff are unable to access the office or if the office is irreparably damaged.
- **Maintaining confidentiality:** If staff are temporarily working off site, plans should work to ensure that the confidentiality of health information required by the Health Insurance Portability and Accountability Act (HIPAA) is maintained. This can include reminding employees to work from a secure, private location and not their kitchens or directing the IT department to program laptop and PC screens to lock after five minutes of inactivity. More importantly, directives should also include prohibitions against printing work material at home. Simply put, your IT department should disable any printing capabilities of the PCs and laptops provided to your staff if they are going to work remotely. The latter issues are important at all times, since many people continue to work remotely either full-time or on a hybrid schedule following the COVID-19 pandemic.
- **Information security:** The security of physical documents when the office space has sustained physical damage is of equal importance. On-site confidential information needs to be safeguarded against unsavory individuals who prey on organizations exposed to disasters. Plans should consider eliminating paper documents to the extent possible and scan documents instead to ensure access to data. You need to ask yourself what type of security can be retained on short-term notice in the event of an unexpected crisis.

Conclusion

Most plan sponsors generally have an acute awareness of their current exposure, reinforced by historical events and their geographic locations. Further, it's hard to imagine that the plan sponsors don't have insurance policies in place to mitigate their risk. However, taking the steps suggested in this article is an additional and likely necessary strategy to

help your plan assess what is needed to sustain operations and minimize damage in times of crisis.

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bio

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Reshaping Employer Health Care With Reference-Based Pricing

by | **Christine M. Cooper** and **Jack M. Towarnicky, CEBS**

Reference-based pricing (RBP) can safeguard health plan participants from excessive medical charges while also saving money for health plan sponsors. The authors outline a three-phase approach for implementing RBP.

Rising health care costs continue to burden plan sponsors and participants alike. Traditional preferred provider organization (PPO) networks—typically offering access to the greatest possible number of providers—often contribute to escalating expenses. The goal is typically to offer a network as broad as possible so that participants can access their desired provider. As a result, negotiated fees with PPOs typically range from 170% to 375% of Medicare rates for the same treatment, at the same facility, from the same providers.[1]

Reference-based pricing (RBP) offers a potential alternative for self-funded plans that may safeguard participants from excessive charges by aligning medical pricing with benchmarks created by the federal government. When RBP is implemented strategically and targets the maximum allowable charge at 125-140% of the Medicare allowable amount, providers typically receive full reimbursement of the cost to provide services. Further, RBP may ease compliance with federal regulations, such as the No Surprises Act (NSA),[2] and may help prevent overpayments and provide a sustainable model for employer-sponsored health benefits.

This article will discuss how RBP may help plan sponsors and participants reduce health care costs and describes a three-phase approach for implementation.

The Challenges of Traditional PPO Networks

Employer-sponsored health plans continue to be the primary source of health care coverage for more than 160 million people in the United States.[3] However, these plans are increasingly burdened by systemic cost shifting, leading to rising expenses for both plan sponsors and participants, including the following.

- **Rising premiums:** Employer-sponsored health plan costs have steadily risen, with employers projecting a 5.8% increase in 2025, (after plans have increased deductibles and other point-of-purchase cost sharing),[4] marking the third consecutive year of growth above 5%.
- **Higher deductibles:** Between 2013 and 2024, the share of covered workers enrolled in single coverage with deductibles exceeding $2,000 increased from 10% to 32%.[5] Over the same period, the average deductible for single coverage rose from $1,135 to $1,787—an increase of 57%. Looking further back, the average deductible has increased 206% from 2006, when it was $584.[6]
- **High provider payments:** Employers frequently pay 170-365% of Medicare rates for identical services provided at the same facilities by the same health care professionals.[7] The difference is even higher when compared with Medicaid.[8]

At the same time, enrollment in taxpayer-funded, fixed-price health care programs like Medicare and Medicaid has expanded, reducing the uninsured population while shifting more costs onto employer-sponsored plans. In the absence of a proactive cost-control strategy, employer-sponsored plans are likely to continue to face premium hikes, larger deductibles and wage stagnation as escalating health care costs consume an ever larger share of employees' total rewards.

RBP may provide a transparent, cost-efficient alternative with the potential to curb excessive spending while protecting the workforce and the employers' bottom line and not reducing quality.

Addressing Cost Inefficiencies and Protecting Employees

One of the most significant advantages of RBP is its ability to establish transparent, predictable and fair pricing for medical services. Unlike traditional PPO networks, where negotiated rates often come with hidden markups, RBP uses a clear, defensible benchmark to determine reimbursement rates.

By anchoring payments to Medicare rates, plan sponsors can substantially reduce expenses paid by the plan and participants, often achieving savings of 15% to 40% compared with traditional, network-based plans. The figure summarizes 326 high-cost claims, each exceeding $50,000, providing an estimate of the savings from applying RBP.

As the figure shows, the gross charge for these 326 claims was $35.5 million, where an estimated $21.2 million of that charge was found to be ineligible under the terms of the various plans. Instead of using a network of providers where the allowable charge averages 254% of Medicare,[9] the plans set the maximum allowable charge at an average of 140% of Medicare. The difference is the estimated maximum savings from deploying RBP, with the estimated split between the plan and participants as highlighted above. (Note: The savings for both the plan and participants will be less for less expensive services or if stop-loss insurance applies.)

takeaways

- When using reference-based pricing (RBP), employer-sponsored health plans typically pay a percentage of Medicare reimbursement rates. This is different from preferred provider organization (PPO) plans that attempt to negotiate rates with providers and direct plan participants to networks.
- The challenges of traditional PPOs include rising premiums and deductibles, while payment to providers are often 170-375% of Medicare rates.
- When implemented strategically, RBP may ease compliance with federal regulations, such as the No Surprises Act (NSA); prevent overpayments; lower the cost for both the plan sponsor and participants; and provide a sustainable model for employer-sponsored health benefits.
- Employers may want to consider a phased approach when implementing RBP. They can start by introducing RBP for out-of-network claims, then expand to certain in-network claims and, finally, transition to a model that applies RBP across all or almost all services to eliminate network-based pricing.
- Challenges of RBP include providers that reject RBP rates and issue balance bills and potentially file lawsuits against participants.

FIGURE

Illustration of Potential Savings From Reference-Based Pricing (RBP) on High-Cost Claims With Initial Billed Charges of More Than $50,000

			Estimated/Assumed					
Number of Claims	Range	Billed Amount	Ineligible or Avoided Expenses	Network @254% of Medicare*	Allowed @140% of Medicare**	Charges Avoided Due to RBP	Plan Paid	Participant Paid
2	$500,000+	$1,405,727	$682,419 48.5%	$645,811	$355,959 25.3%	$367,349	$355,186 99.8%	$772 0.2%
121	$100,000-$499,999	$19,770,412	$12,732,077 64.4%	$6,284,228	$3,463,748 17.5%	$3,574,587	$3,323,689 96.0%	$140,058 4.0%
203	$50,000-$99,999	$14,310,459	$7,778,505 54.4%	$5,832,102	$3,214,544 22.5%	$3,317,410	$2,848,987 88.6%	$365,557 11.4%
326		**$35,486,597**	**$21,193,000 59.7%**	**$12,762,140 40.3%**	**$7,034,251 49.2%**	**$7,295,347 50.8%**	**$6,527,862**	**$506,388**
			Estimated Maximum Savings Due to RBP				**$6,736,754**	**$522,593**

*Per *Hospital Price Transparency Study 5.0.* RAND.
**Typical RBP Structure (125-150% of Medicare)
Source: aequum, LLC. Billed amounts, allowed amounts and benefits paid from aequum, LLC records. Estimates of ineligible or avoided expenses, comparable network fees and charges avoided due to RBP based on authors' calculations. Totals may not add up due to rounding.

Participants could benefit from lower out-of-pocket costs and lower contributions as coverage remains affordable. Beyond cost control, RBP also may protect participants from overpayment and surprise medical bills. When coupled with strong participant advocacy programs that provide negotiation support and legal defense when disputes arise, RBP can safeguard participants from excessive provider fees and balance billing.

RBP may also minimize the cost of complying with NSA, a law that took effect in 2022 to protect health plan participants from certain surprise medical bills. Because RBP plans have limited networks or no networks, NSA doesn't apply in the same way it would for a traditional network PPO plan design. A full discussion of NSA compliance is beyond the scope of this article.

RBP Challenges

RBP is not without its challenges, and a recent survey from the International Foundation of Employee Benefit Plans found that only 5.3% of organizations used RBP as a cost-management technique in 2024.[10]

Because RBP plans operate outside traditional networks, participants may encounter providers who reject RBP rates and issue balance bills for the remaining charges. In rare cases, this can escalate into legal action against the patient, unless strong advocacy support is provided. Where these disputes are allowed to cause confusion and stress for participants, RBP can be a "noisy" solution.

For this reason, successful RBP models depend on proactive communication, clear plan design, and robust advocacy and dispute resolution services that shield plan members from these risks and help them navigate care confidently.

Best Practices for Plans Transitioning From PPOs to RBP: Three-Phase Approach

Successfully shifting from a traditional PPO structure to an RBP model requires a well-planned transition that allows plan sponsors to assess cost savings, refine implementation strategies and build participant confidence in the new system. By gradually integrating RBP, plans can ensure a smooth shift while avoiding participant confusion or resistance.

Plans transitioning to RBP may prefer a phased approach that optimizes chances for success. This strategy begins with introducing RBP for out-of-network claims where NSA does not apply, then extends the use of RBP to all providers other than those delivering primary care and later expands to a pure RBP model that eliminates reliance on network contracts altogether.

At each step in the process, the plan sponsor should clearly communicate the potential cost savings that RBP achieves for participants.

Phase 1: Introducing RBP for Out-of-Network Claims

The first step of a phased approach to implementing RBP is to apply it exclusively to non-network claims, keeping the existing PPO framework intact.

To execute this phase effectively, plans may want to consider partnering with a claims administrator (TPA) with experience in RBP administration to provide pricing information as well as advocacy support for participants. A strong patient advocacy program helps to navigate billing disputes and to negotiate with providers. During this stage, it is crucial to track cost reductions and establish baseline comparisons to quantify RBP's financial impact.

Plan sponsors should clearly communicate to participants that out-of-network pricing will now be based on a transparent, market-driven benchmark and confirm how the new benchmarks will reduce participant costs.

Phase 2: Expanding RBP and Communicating Savings

Following the successful introduction of RBP for out-of-network claims, the next step is to expand its application to certain in-network services while reinforcing its value to participants. Plans can begin by applying RBP to specific high-cost services, such as imaging, outpatient procedures and elective surgeries, while retaining PPO contracts for primary care and routine visits.

Plans can use real-world examples and case studies to illustrate how RBP has successfully lowered medical costs for participants. Educating participants on how to navigate the RBP plan can empower them to make cost-effective health care choices without compromising quality of care. In addition, it is crucial to reinforce the availability of patient advocacy resources, ensuring that participants have the support they need to resolve billing concerns and avoid excessive charges.

In this phase, the plan sponsor should also reevaluate in-network vs. out-of-network cost sharing given the curtailment of network providers. For example, plans may want to eliminate separate deductibles and out-of-pocket expense maximums for out-of-network providers.

Phase 3: Transitioning to a Pure RBP Model

The final step in the transition is to fully replace PPO network agreements with a pure RBP model. At this stage, RBP would apply across all services, and network-based pricing structures are eliminated entirely.

How RBP Works in Practice for Participants

Unlike traditional preferred provider organization (PPO) networks that come with a preapproved list of in-network providers, referenced-based pricing (RBP) plans typically do not rely on fixed networks. Instead, participants can seek care from any provider, with reimbursement rates based on a predetermined benchmark, usually a percentage of Medicare pricing.

Participants are not expected to shop for care entirely on their own. Most RBP administrators, which may be the claims administrator or third-party administrator (TPA), offer access to tools and support services that help participants identify providers likely to accept RBP terms or providers who have a history of cooperating with RBP plans. Some plans choose to create informal lists of preferred providers based on prior positive experiences or negotiated arrangements.

Patient advocacy services are also central to making RBP a success. These services often include previsit provider outreach, price confirmation and assistance with billing negotiations. If a provider disputes the RBP reimbursement, the advocacy team steps in to resolve issues, minimizing employee involvement and preventing surprise bills. In many cases, participants are also encouraged to contact advocacy teams before seeking nonemergency care to receive guidance on how best to proceed.

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Education

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To support this transition, provider negotiation strategies should be strengthened to mediate billing disputes and ensure that participants are not exposed to balance billing risks. In addition, plan designs should be adjusted to ensure that cost-sharing mechanisms (such as contributions, deductibles and out-of-pocket maximums) clearly confirm the participant savings from RBP. Plan sponsors should clearly communicate the financial advantages of transitioning to a pure RBP model, emphasizing lower premiums and reduced out-of-pocket costs. To encourage cost-effective choices, offering incentives for using RBP-preferred providers can further reinforce the benefits of the model.

In addition, ongoing support through patient advocacy and education programs is essential to ensure that participants feel informed, supported and confident in managing their health care coverage.

The Future of Employer-Sponsored Health Care With RBP

By anchoring allowable expenses to market-based benchmarks, RBP may represent a solution that can control cost while ensuring high-quality coverage for plan participants.

With rising health care costs, evolving regulations and ever-increasing financial pressures on both plan sponsors and participants, plan sponsors may find that RBP provides them with a cost-efficient, compliant and sustainable health care model for the future.

bios

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Engaging ERGs to Drive Deeper Financial

by | **Liz Davidson**

Wellness

Integrating diversity, equity and inclusion (DEI) strategies into financial wellness programs can help organizations drive lasting improvements in their employees' financial well-being—especially when programs work through trusted peer networks, such as employee resource groups (ERGs).

Financial wellness programs have proven to be a powerful driver of positive change for many employers. They can reduce financial stress, increase employees' sense of agency and boost confidence—benefits that ripple across every aspect of life and work, from productivity to long-term career growth.

These impacts may deepen significantly when programs are delivered in partnership with employee resource groups (ERGs) that already coalesce around shared identity—including race, culture, life circumstances, gender and ability. This approach can help them develop content and delivery methods that reflect employees' lived experiences. ERGs cover a wide range of groups with similar experiences, including women who historically need to save longer for retirement; members of minority groups who typically earn less, have similar lived experiences, and look at money through their unique cultural lens; single parents who must plan without the financial or emotional help to a spouse; neurodiverse employees who learn and process information differently; or employees with disabilities or life circumstances that must be factored into their financial planning.

By tapping into the trust, insight and connection already encouraged within ERGs, organizations can co-create financial wellness strategies that resonate deeply. This article provides key best practices—used in several large employers' financial wellness programs—and insights into how they partnered with ERGs to deliver measurable results.

takeaways

- Collaborating with employee resource groups (ERGs) that represent identity groups such as women and minorities can help employers design and deliver financial wellness programming that reflects employees' unique experiences.
- ERGs can help to ensure that financial content addresses challenges—such as caregiving, intergenerational debt or systemic financial barriers—faced by certain groups.
- Employers can develop peer panels that bring together members from different ERGs to allow employees to share diverse perspectives, experiences and strategies for navigating financial challenges. These panels often reveal common concerns that resonate across different employee groups.
- Employers should gather data on metrics such as financial wellness program participation, reengagement, stress levels and behavioral changes in financial decision making and adjust content where needed.
- Research has shown that financial wellness programs that involve ERGs see higher participation and reengagement rates.

1. Start by Listening: Empowering ERGs to Lead the Way

The most effective solutions come from those who experience the challenges firsthand—employees. ERGs, when empowered as active, peer-led partners, can offer an authentic window into the real-world financial struggles and needs of a workforce. They provide insider insights that help programs resonate with the people they're meant to assist.

Why does this matter? Because top-down financial wellness programs rarely hit the mark. They can miss key issues that only employees rooted in specific communities truly understand. That's where ERGs come in—They not only identify these gaps but also bring the context and lived experience that turn general guidance into actionable, tailored strategies they feel they can use.

Best Practice

Design ERGs to be peer-led, not top-down. Empower these groups to play a central role in shaping and personalizing the financial wellness program, ensuring that it aligns with the unique needs of employees.

How to do this well involves the following.

- **Listen genuinely.** Use surveys, focus groups and candid conversations to understand the specific financial struggles different employee groups face.
- **Involve ERGs early.** Don't just ask for feedback—Invite them to co-create. When ERGs are part of the process, they become advocates for the program, which increases its authenticity and potential to improve employees' lives.

Example

The LGBTQ+ ERG at a large employer identified a critical gap—Employees in certain states couldn't access partner benefits due to legal restrictions. Instead of simply flagging the issue, the ERG and the company's financial wellness vendor collaborated to create a customized webcast on estate planning and insurance strategies to overcome the challenges this community faces to secure policies that help protect their families.

2. Use AI and ERGs to Personalize Programming

As financial wellness programs evolve, personalized experiences have become a fundamental part of their success.

Artificial intelligence (AI) has emerged as a tool that enables organizations to deliver highly individualized guidance based on employee behaviors, goals and preferences. Through AI, companies can automate nudges, offer personalized content, and integrate broader benefits and tools that align with each employee's financial needs, creating a more tailored experience.

However, while AI may be crucial for cost-effective implementation of these efforts, ERGs can provide the human connection to overcome emotional barriers that keep employees from acting. ERGs help to ensure that financial content addresses challenges—such as caregiving, intergenerational debt or systemic financial barriers—faced by certain groups, creating a more comprehensive approach to financial wellness.

Best Practice

Use AI to implement personalization, and pair it with ERG input to make sure that the content is culturally relevant and addresses real-life challenges. This collaboration may lead to smarter delivery, meeting employees' needs and providing actionable steps to achieve their goals. This, in turn, can lead to better outcomes in employees' wellness.

Example

Employees who participated in an ERG-driven financial wellness program that included both digital and human financial coaching at a large financial institution reported the following outcomes.

- 40% of employees who carried high-interest debt have now eliminated it.
- 56% of employees who previously lacked positive cash flow now report a monthly surplus—highlighting the lasting impact of personalized, culturally relevant support.
- 61% of employees who had no emergency savings now have at least $1,000 set aside for unexpected expenses.

The Results: What Happens When Organizations Integrate ERGs Into Financial Wellness

Organizations that intentionally integrate ERGs into their financial wellness programs are likely to see significant improvements in employee engagement, behavior change and cultural trust. By giving ERGs a seat at the table—from program design to delivery—employers should be better equipped to meet the diverse financial needs of their workforce while strengthening inclusion and belonging.

Following are some key outcomes experienced by the organizations mentioned in this article.

- **Higher engagement and reengagement:** Programs involving ERGs consistently see up to two times higher participation than standard offerings. One large health care provider saw a 65% reengagement rate after offering ERG-specific webcasts: Of 699 initial attendees, 458 engaged in another financial wellness service.
- **Meaningful stress reduction:** Forty-one percent of employees who had unmanageable financial stress reduced their stress to manageable levels, and 91% of employees who reported they were in the "crisis/struggling" phase moved to the "planning/optimizing" phase.
- **Stronger trust and representation:** When coaches reflect participants' identities and ERGs shape content, employees report feeling more supported and better understood—driving deeper connection and learning through repeat usage of the program. More than three-quarters (76%) of employees who participated in the large financial institution's program reengaged later on, and employees proactively sent thank-you notes to their human resources (HR) and benefits leaders.
- **Sustained cultural impact:** ERG-led efforts contribute to a culture of equity and support that may align with organizational goals and enhance organizational cohesion.

3. Build Connection Through Peer Panels and Cross-ERG Collaboration

While addressing the unique financial needs of each community is crucial, organizations are increasingly finding value in fostering connections across ERGs. Peer panels that bring together members from different ERGs allow employees to share diverse perspectives, experiences and strategies for navigating financial challenges. These panels often reveal common concerns that resonate across different employee groups.

By creating space for employees to connect on these shared issues, organizations can help reduce the stigma often associated with financial stress and promote a sense of solidarity. What may feel like an individual struggle

for one group becomes a collective challenge, empowering employees to find mutual support and solutions. This kind of cross-group learning encourages open, candid conversations about finances—something that traditional financial training rarely fosters.

Moreover, these interactions can provide a richer, more holistic view of financial wellness, bridging the gap between different racial and cultural groups and helping employees see how their experiences overlap with others. This shared learning increases financial knowledge and also strengthens the sense of community within the organization.

Best Practice

Facilitate peer-led panels and cross-ERG collaboration to promote shared learning and mutual support. This approach allows employees to connect on common financial challenges, build empathy and enhance overall engagement in financial wellness programs.

Example

At a large health care organization, a cross-ERG panel with four distinct groups discussing money perspectives sparked widespread interest in additional sessions. Employees left the session feeling more informed, connected and eager to participate in future discussions—demonstrating the power of shared learning.

That same employer also saw powerful behavior change from its program across racial demographics who face disproportionate levels of financial stress, demonstrated by the following statistics.

- 75% of Native American employees experienced a reduction in high or overwhelming financial stress.
- 50% of Black employees saw the same reduction.
- 48% of Hispanic/Latino employees reported the same reduction.

4. Measure the ROI of Financial Wellness Programs for ERGs

Integrating ERGs into financial wellness initiatives can also drive measurable business outcomes. When ERGs actively contribute to the design and delivery of financial wellness programs, organizations can see significant return on investment (ROI) through improved employee engagement, productivity and reduced turnover. ERGs can also produce tangible cost savings. These include reductions in absenteeism, garnishments and health care expenses as well as fewer delayed retirements. The financial benefits of these programs often surpass initial expectations, reinforcing the case for incorporating ERGs as key partners in any financial wellness strategy.

bio

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Best Practice

Track participation, financial behavior changes, return usage and long-term financial preparedness among different employee groups and demographics. By measuring these factors, organizations can better assess the impact and refine their programs and DEI-specific initiatives, in particular, for greater success.

Example

A Financial Finesse ROI model estimates that a large employer with 50,000 employees could experience $4.26 million in savings from reduced absenteeism, $13.57 million in health care cost reductions and significant savings from reduced employee turnover.

5. Connect Financial Wellness Across Benefits Offerings

While it is not specific to ERGs, another best practice is to take a holistic approach to financial wellness, integrating employees' full range of benefits and marrying them with financial support to help them make informed financial decisions at every stage and in each circumstance of their lives.

Financial stress is not only a personal issue—It is a significant factor affecting employee productivity, engagement and overall well-being. As research has shown, employees are increasingly stressed about their finances, which can lead to burnout and disengagement.

When financial wellness is embedded within the broader benefits ecosystem, employees may be more likely to engage with the program and their overall benefits packages, see the value and experience improved overall well-being. This integration can foster a stronger connection between financial health and other aspects of employees' lives, encouraging greater participation in financial wellness offerings.

Best Practice

Ensure that financial wellness is seamlessly integrated with other benefits programs, including retirement and health plans. When employees see the connection between financial wellness and their broader well-being, they are more likely to engage with and benefit fully from the program.

Example

A health care company that infused personalized benefits guidance into its financial wellness program saw a 50% average increase in participant retirement plan deferral rates and a 41% average increase in health savings account contributions among employees who engaged with the program.

Final Takeaway

Personalization has long been a cornerstone of financial wellness initiatives. When organizations take the time to tailor these offerings to specific employee needs through ERGs, they often achieve stronger engagement and measurable outcomes.

Last spring, the Equal Employment Opportunity Commission (EEOC) released informal guidance on diversity, equity and inclusion programs, including the operation of employee resource groups (ERGs). Check out the International Foundation's Presidential Administration and Employee Benefits toolkit for the latest EEOC guidance on DEI programs and other compliance issues. Visit www.ifebp.org/toolkits for more details.

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Failure to Produce Plan Documents Not a Violation of ERISA

BENEFIT LITIGATION

The U.S. Court of Appeals for the Fifth Circuit affirms the district court's decision in a suit related to the request for settlement proceeds, finding that failure to produce plan documents did not violate the Employee Retirement Income Security Act of 1974 (ERISA).

Background

The plaintiff is the executor and administrator of the estate of a former participant in an employer-sponsored retiree medical plan. The defendant is the employer and sponsor of the plan. ERISA governs the plan.

As executor and administrator of his mother's estate, the plaintiff filed this lawsuit against the defendant. The decedent was a participant in the plan. After sustaining serious injuries in a car accident caused by a third party, the defendant paid over $451,000 in accident-related medical benefits with respect to the participant. A few years later, the participant passed away. The defendant subsequently filed a lawsuit seeking a constructive trust or equitable lien over the car accident settlement proceeds. In connection with that lawsuit, the plaintiff's counsel sent an information request to the defendant pursuant to ERISA Section 104(b)(4), seeking plan documents related to the health benefits, rights and payments for the medical treatment provided to the participant. In response, the defendant produced over 12,000 pages of documents, along with a description of the materials. The lawsuit was resolved several months later, and the action was dismissed. Three months after the dismissal, the plaintiff filed a suit against the defendant, seeking discretionary penalties under ERISA Section 502(c)(1) for the defendant's alleged failure to produce the required documents.

A bench trial was held, during which the plaintiff specified that the defendant's alleged failure to produce three documents formed the basis of his argument that the defendant did not comply with 29 USC §1024(b)(4). The defendant testified that these three documents were not produced because the statute did not require disclosure. The district court agreed with the defendant and entered judgment in its favor. The plaintiff filed a motion to reconsider, which the district court denied. The plaintiff now appeals the denial of that motion.

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

Decision: An employer took reasonable care to provide documents related to a deceased plan participant's accident to the participant's son and therefore did not violate ERISA.

Arguments and Discussion

The court now reviews the district court's discovery rulings for an abuse of discretion. The court addresses three issues: (1) whether the district court abused its discretion by limiting the scope of discovery, (2) whether the district court abused its discretion by denying the plaintiff's request for leave to amend his complaint and (3) whether the plaintiff is entitled to civil penalties under ERISA Section 502(c)(1) for the defendant's alleged failure to comply with the production request.

The court first addresses the plaintiff's argument that the district court's denial of his motion to compel discovery was an abuse of discretion. The lower court granted in part and denied in part the plaintiff's motion, rejecting some of the discovery requests on the grounds that they were irrelevant and disproportionate. The court sustained objections to the plaintiff's attempts to seek discovery on matters more related to the car accident settlement lawsuit than to ERISA Section 104(b)(4). The district court denied the plaintiff's motion to reverse the lower court's decision, finding no clear error. It noted that the plaintiff already had the relevant documents related to the

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Failure to Produce Plan Documents Not a Violation

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plan participant's benefit plan and that the plaintiff's request was essentially a fishing expedition. The court agrees with the district court's decision, finding that the plaintiff failed to demonstrate that the lower court's rulings were arbitrary or unreasonable. Thus, the district court did not abuse its discretion in upholding the lower court's review of the plaintiff's document requests.

Next, the court addresses the plaintiff's claim that the district court abused its discretion by denying him leave to amend his complaint. The plaintiff filed his motion for leave to amend 15 months after initiating the lawsuit and nine months after the deadline to amend. The proposed amendments sought to add claims for breach of fiduciary duty and failure to produce plan documents related to nonmedical benefits. Generally, amendments after the scheduling order deadline are permitted only if the movant demonstrates reasonable cause to modify the order. Four factors are considered when assessing good cause; however, on appeal, the plaintiff does not explain how he meets any of these factors. Instead, the plaintiff merely asserts conclusively that he meets the good cause requirements and points to his briefing. As a result, the court finds that the plaintiff had failed to establish that the district court abused its discretion in denying the motion to amend.

Finally, the court addresses the plaintiff's sole claim that the defendant failed to provide certain documents in response to his request for production and that he is, therefore, entitled to discretionary penalties. The court acknowledges that, under ERISA, a plan administrator must furnish documents such as the latest summary plan description, annual report, terminal report, bargaining agreement, trust agreement and other documents related to the plan's operation. The district court concluded that the alleged violations did not warrant penalties. It reasoned that the defendant did not intentionally withhold any relevant documents, did not act in bad faith and took reasonable care to ensure that all documents were produced. The court finds that the plaintiff has not demonstrated that the district court abused its discretion in making these determinations. The plaintiff did not allege bad faith in his complaint and claimed he lacked access to the defendant's grievance procedure; however, the court disagrees, finding that the defendant provided him with the agreement containing the grievance procedure he sought. For these reasons, the court determines that the plaintiff has failed to show that the district court abused its discretion in concluding that the alleged violations did not warrant penalties.

Accordingly, the court affirms the district court's decision to uphold the lower court's denial of the plaintiff's motion to reconsider, finding that the district court did not abuse its discretion.

Jones v. AT&T et al., No. 24-30187 (Fifth Cir., March 6, 2025).

Compensation Award Upheld Despite Lack of Executed Agreement

The U.S. Court of Appeals for the Eighth Circuit affirms the district court's decision in a suit related to a claim for benefits under a deferred compensation plan, finding that the plaintiff was owed compensation regardless of not signing an employment or confidentiality agreement.

Background

The plaintiff is a former executive seeking compensation under a deferred compensation plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The defendant is the plan sponsor.

The plaintiff was an executive who participated in the plan, which was a top-hat plan that delayed compensation for high-earning employees. Under the plan's terms, the plaintiff could earn 5% of the defendant company's fair market value upon his exit from the company, with full vesting occurring at five years. The plaintiff stayed at the company for four years, which resulted in a nonforfeitable percentage of 80%. The plaintiff resigned and sought his vested compensation. His resignation was a triggering event under the plan, and the event commenced a process set out in the plan and required by ERISA. The first step required the defendant to make an initial determination of benefits, and if the plaintiff disagreed with the determination, he could file a written claim for benefits. If the defendant denied the written claim, the plaintiff could appeal, and if his appeal was denied, having exhausted his administrative remedies, he could file an action in federal court.

The parties followed the established process, but the defendant refused to pay the plaintiff before the plan's stated payment deadline. This was treated as an initial determination, and the plaintiff responded with a written claim for benefits, which the defendant denied. The defendant explained that the plaintiff had not signed two key agreements—an employment agreement and a confidentiality agreement. Both parties acknowledged that neither agreement had been signed. The defendant concluded that since these agreements did not exist when the plaintiff began performing under the plan, it was the plaintiff's responsibility to create them. The defendant argued that without these agreements, it could not determine whether the plaintiff had breached his covenants, and without resolving the breach question, it could not make a benefits determination under the plan.

The plaintiff appealed this decision, asserting that he was not required to draft, propose and sign the agreements at issue. The defendant denied the appeal and asserted that the plaintiff was required to draft, propose and sign an employment agreement and a confidentiality agreement. The defendant also asserted that the plaintiff had engaged in misconduct by inflating the company's assets and income. The plaintiff eventually appealed to the federal court under ERISA's enforcement provisions.

The district court concluded that the plan did not require the parties to create an employment and/or confidentiality agreement. It found that the parties knew those agreements did not exist when the plan was drafted, did not condition enforceability on their existence and operated under the plan. Further, the defendant never raised the employment or confidentiality agreement issues

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

Decision: A former executive is entitled to benefits under his employer's top-hat plan even though he did not sign an employment or confidentiality agreement because the plan did not require those agreements, and they did not exist when the top-hat plan was drafted.

TOP-HAT PLANS

Compensation Award Upheld
continued from previous page

until after the plaintiff sought compensation under the plan. The district court found that the facts inferred the defendant was simply looking for a way to avoid its obligations, also determining that any claims of misconduct by the plaintiff were unsubstantiated. The district court ruled in favor of the plaintiff and granted his request for attorney fees. The defendant now appeals both decisions.

Arguments and Discussion

The court reviews the decision on the underlying benefits de novo. First, the court addresses the defendant's argument that the plaintiff was required to sign both an employment agreement and a confidentiality agreement before he could accept the plan terms. The court disagrees, noting that the plan is a unilateral contract, where an offer is accepted by performance. The court finds that the plaintiff had performed under the plan by remaining an employee without being terminated for cause until a triggering event occurred. Additionally, the court observes that the plan contemplated forfeiture of benefits if the plaintiff breached the employment or confidentiality agreements, even though these agreements did not exist.

The defendant argues that because the two agreements did not exist when the plaintiff began performance under the plan, the burden was on the plaintiff to create them if he wanted to claim the plan's benefits. The defendant counters that the plan terms were ambiguous and that its interpretation required the plaintiff to create the agreements to resolve the ambiguity. The court, however, disagrees, finding that the plan terms created a clear conditional rule: If the plaintiff breached either agreement, he would forfeit his benefits. This rule was valid even though no agreement existed when the plaintiff fulfilled his obligations under the plan. The court explains that, had the agreements been created, the plaintiff's benefits would have become conditional upon his compliance with them.

The court also rejects the defendant's argument that the agreements could be construed as conditions precedent, stating that nothing in the plan required the plaintiff to enter into the agreements. Furthermore, the court disagrees with the defendant's assertion that it reasonably consulted extrinsic evidence to find ambiguity in the plan terms. The court finds the defendant's interpretation unreasonable, noting that under ERISA, an employee's entitlement to benefits is governed by the plan documents, not company customs. Since the contract's plain language did not create ambiguity, the court concludes that the defendant's creation of ambiguity was unreasonable.

Next, the court reviews the decision related to attorney fees for an abuse of discretion. The defendant argues that the district court abused its discretion when awarding the plaintiff attorney fees because the defendant had evidentiary support for its decision. The court revisits the defendant's actions of only raising the lack of employment and confidentiality agreements after the plaintiff sought his vested compensation, hesitating to explain its denial decision to the plaintiff and reaching an unreasonable interpretation of the plan terms. Based on these circumstances, the court finds that the district court did not abuse its discretion when granting the motion for attorney fees in favor of the plaintiff.

Accordingly, the court affirms the district court's decision to award the plaintiff's benefits and attorney fees.

Hankins v. Crain Automotive Holdings, LLC, No. 24-1555 (Eighth Cir., February 28, 2025).

Court Vacates Prior Dismissal and Order to Arbitrate Fiduciary Breach Claims in Class Action Suit

The U.S. District Court for the Western District of Kentucky grants the plaintiffs' motion to reconsider and vacates a prior order granting dismissal of claims and ordering for arbitration in a class action suit for fiduciary breach in connection with an ESOP.

Background

The plaintiff includes a former participant on behalf of himself and a class of similarly situated plan participants under an employee stock ownership plan (ESOP). The defendants include the company that sponsors the ESOP and the individual ESOP fiduciaries. The ESOP is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs participated in the defendants' ESOP. They filed a class action complaint under ERISA, alleging one count of breach of fiduciary duty and one count of engaging in a prohibited transaction. In the procedural history, the defendants moved to dismiss the plaintiffs' class action complaint and compel arbitration. The court granted the motion to dismiss, finding that the plaintiffs had signed valid individual arbitration agreements as part of their employee agreements, which required their claims to be resolved through arbitration. This decision left the plaintiffs' allegations pending against only one of the defendant individual fiduciaries.

In response, the plaintiffs filed a motion to reconsider the order compelling arbitration, arguing that the decision was a clear error of law because their claims were not individual but belonged to the ESOP. They further contended that the court had already rejected the application of the ESOP arbitration agreement in its prior analysis. The plaintiffs also argued that reconsideration was warranted based on manifest injustice, asserting that their claims could not proceed in class arbitration and that pursuing claims against the one remaining defendant alone would significantly limit their potential judgment.

The defendants moved the court to amend the previous order and requested a stay in favor of arbitration rather than dismissal due to a change in relevant case law.

The plaintiffs now move the court again to reconsider its order granting dismissal in favor of arbitration. The plaintiffs argue that the court must reconsider its previous order because of the change in controlling case law.

Arguments and Discussion

The court begins its analysis by addressing the standard for reconsideration. Courts typically find grounds for reconsidering interlocutory orders when there is an intervening change in controlling law, as is the case here. Having determined that the motion was filed in a timely manner, the court proceeds to assess whether the decision to grant dismissal of the claims in favor of arbitration should be altered, amended or vacated. The plaintiffs argue that the newly issued precedent ensures that claims brought on behalf of an ERISA plan or its participants cannot be forced into individual arbitration. Further, individual arbitration provisions cannot waive statutory rights and remedies on behalf of a plan or its participants and, therefore, are not enforceable.

Unlike the defendants, who argue that the change in relevant case law is not controlling and

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Court: U.S. District Court for the Western District of Kentucky

Decision: A class of former ESOP participants sufficiently alleged that the plan sponsor and fiduciaries violated their fiduciary duties by engaging in a prohibited transaction and causing the plan to sell its stock below market value, and the suit may continue.

FIDUCIARY DUTIES

Plaintiff's Life Insurance Claim Alleging Systemic Racism in Policies Dismissed

DISCRIMINATION

The U.S. District Court for the Northern District of Texas dismisses the plaintiff's claim for life insurance benefits in a suit alleging systemic racism in the plan administrator's policies, finding that the claim was duplicative of another claim in the same suit.

Background

The plaintiff is the named beneficiary of a deceased participant in his employer-sponsored insurance plan. The defendant includes the insurance company that insures and administers the life insurance benefits under the plan and a claims analyst who works for the insurance company. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

After the plaintiff's husband died in a car accident, the plaintiff submitted a claim on his life insurance policy, seeking benefits. The defendant denied the claim, stating that the deceased was allegedly in the United States illegally. The plaintiff then sued for state law claims in state court. The defendants removed the claims to federal court and moved to dismiss the state law claims and strike the plaintiff's jury demand.

In response, the plaintiff filed an amended complaint, dropping the state law claims and keeping the jury demand but adding ERISA claims for wrongful denial of benefits and unfair or deceptive settlement practices. The plaintiff argued that under ERISA Section 502(a)(3), (1) the defendants denied her claim for dependent life insurance and accidental death and dismemberment benefits due to her race and/or ethnicity, (2) the defendants misrepresented the terms of the plan in order to deny her of dependent life insurance benefits and (3) the defendants failed to accept that the plaintiff's deceased husband was in the U.S. legally.

The defendants filed a motion to dismiss the plaintiff's ERISA claims, specifically the claim under ERISA Section 502(a)(3), as duplicative. The defendants also moved to dismiss an improper party and strike the plaintiff's jury demand.

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

Decision: A claim for monetary relief by the wife of a deceased plan participant, who alleged that she was denied life insurance and AD&D benefits because of her race and/or ethnicity, is dismissed because it contains duplicative claims and an improper party.

Arguments and Discussion

The court begins its analysis by considering whether the plaintiff has made a duplicative claim. Unlike most civil cases, alternative pleading of a catch-all claim is generally not allowed in ERISA cases. The Fifth Circuit has ruled in previous case law that relief under ERISA Section 502(a)(3) is typically unavailable when the plaintiff can seek monetary relief under ERISA Section 502(a)(1)(B). The defendants argue that the plaintiff's complaint presents a straightforward benefits claim under ERISA Section 502(a)(1)(B), pointing to her allegations that the defendants denied her claim for benefits despite knowing that her deceased husband was legally in the U.S. and that the defendants misrepresented the plan terms to deny the plaintiff's dependent life insurance benefits. In contrast, the plaintiff contends that the case involves more than just policy benefits, asserting that the ERISA Section 502(a)(1)(B) claim seeks benefits, while the ERISA Section 502(a)(3) claim aims to enjoin the defendants' actions regarding the policy benefits.

The court agrees with the defendants' arguments. While the court acknowledges the plaintiff's desire to enjoin the defendants' alleged racist practices, separate from her claim for benefits under ERISA Section 502(a)(1)(B), and recognizes that the plaintiff has made specific, plausible allegations

of racial discrimination, her request remains duplicative. The court reasons that if the plaintiff's claim for benefits succeeds, there would be no further policy benefits to seek and, therefore, her injunction request regarding the policy must be dismissed.

Next, the court looks at the allegations brought against the claims analyst. The defendants argue that the plaintiff's amended complaint fails to make plausible allegations against the claims analyst, asserting that, as a claims analyst, the individual is not a party to the contract and is not a proper defendant in an ERISA claim. The court agrees, stating that a proper ERISA defendant in a benefits claim is the party that controls the plan's administration. The plaintiff's complaint does not specify how the claims analyst controls the plan or is involved in its administration. Therefore, the court grants the defendants' motion to dismiss the claims analyst.

Finally, the court considers the plaintiff's demand for a jury trial. The court agrees with the defendants that there is no right to a jury trial in an ERISA benefits claim. The plaintiff argues that her claim for back pay is compensatory and triggers her right to a jury trial, but the court finds this argument unpersuasive and inconsistent with established precedent.

Consequently, the court grants the defendants' motion to dismiss for duplicative claims and improper parties and strikes the plaintiff's jury demand.

Flores v. Hartford Life and Accident Insurance Company et al., No. 3:23-cv-2687-x (N.D.Tx., January 30, 2025).

Trustee's Motion to Dismiss Revived Claims in ESOP Inflated Valuation Suit Denied

STOCK PLANS

The U.S. District Court for the Eastern District of Wisconsin denies the defendant's motion to dismiss revived claims from a prior suit involving a fiduciary breach and the inflated valuation of an employee stock ownership plan (ESOP).

Background

The plaintiff is the administrative committee of an ESOP. The defendant is the trustee of the ESOP. The ESOP is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

After its owner attempted to sell a paper products company on the open market, the company was ultimately sold to its employees and structured as an ESOP. The sale required the creation of a new holding company, and the paper products company employees contributed millions from their retirement accounts to buy 100% of the holding company's stock. The holding company, along with $700 million in loans, used the money to buy 100% of the paper products company's stock for its appraised value of $810 million. Once the sale was finalized, the paper products company formed the ESOP committee.

The plaintiff committee was the named fiduciary of the ESOP and appointed the defendant as the first trustee as part of its responsibilities. The defendant was responsible for recalculating the fair market value of the paper products company stock twice a year. The ESOP also required the defendant to hire an independent appraiser to help it accomplish the task. The appraiser was expected to conduct an independent appraisal of the paper products company, and the defendant would then review the independent appraisal, finalize a share price based on the appraiser's valuation and report the share price to the plaintiff. The plaintiff would then review, approve and report the share price to the ESOP participants.

The defendant trustee was appointed in March 2001 and served until March 2013. From November 2012 onward, the defendant reviewed and approved only one stock valuation. During this time, the defendant's appraiser issued a valuation that assessed the paper products company stock at $17.55 a share, as of December 2012. The defendant reported this valuation to the plaintiff, who ultimately approved and adopted it. A few months later, the defendant resigned and was replaced by a second trustee. Using the same methodology as in the December 2012 valuation, the appraiser recommended a share price of $17.85 for June 2013 to the second trustee. The second trustee reviewed and approved the appraiser's valuation and, later, the plaintiff approved the share price. During the ESOP's semiannual stock purchase in June 2013, the plaintiff, relying on the second trustee's approval of the two prior valuations (from December 2012 and June 2013), used the lower valuation of $17.55 from December 2012 to purchase stock. Through the December 2013 stock repurchase cycle, the second trustee continued in its role, and the plaintiff purchased shares using the valuation of $17.85 from June 2013.

As this process for the valuation and purchase of shares continued, the paper products company's business steadily declined and, in October 2017, the paper products company filed for bankruptcy. In connection with the bankruptcy, the plaintiff, as the newly sole member of the ESOP committee, initiated this suit on behalf of the ESOP.

The plaintiff alleges that the defendant breached its fiduciary duty by approving the appraiser's allegedly inflated valuations. The plaintiff

Court: U.S. District Court for the Eastern District of Wisconsin

Decision: An ESOP administrative committee's claims that the ESOP trustee caused harm to the plan by using inflated valuations when selling company stock to plan participants may continue since it was filed in a timely manner.

also asserts a co-fiduciary breach claim, alleging that by approving the appraiser's valuations without adequate scrutiny, the defendant allowed the plaintiff to rely on those valuations when purchasing shares.

Procedurally, the district court first entered a final judgment in favor of the defendant and dismissed almost all of the plaintiff's claims. The plaintiff appealed to the Seventh Circuit, and the court revived and restored some of the previously dismissed claims against the defendant, allowing the plaintiff to proceed on its primary claims that the defendant breached its fiduciary duty. The defendant now seeks the dismissal of the revived claims against it.

Arguments and Discussion

On appeal, the plaintiff raises two issues, including (1) whether the district court erred in determining that the second amended complaint failed to state any ERISA claims against the defendant and (2) whether the district court erred in requiring acts of fraud or concealment separate from the underlying ERISA violations to toll the statute of limitations. In its decision, the Seventh Circuit held that the plaintiff adequately pled breach of the duty of loyalty by the defendant after alleging that the defendant looked the other way at inflated valuations because they wanted to keep the paper product company's business.

The court also held that the plaintiff adequately pleaded claims for the breach of duty of prudence because the defendant was careless in failing to scrutinize the appraiser's valuation methods. Next, with respect to co-fiduciary liability, the court found that the plaintiff adequately pleaded this claim because the defendant's action of approving the appraiser's valuations without sufficient scrutiny allowed the plaintiff to accept and use those valuations to authorize share purchases. The court concluded by reversing the dismissal of claims to the extent they sought recovery and remanded the claims to this court for further proceedings. In finding that the plaintiff adequately stated a claim against the defendant, the court did not address causation because the defendant did not raise the issue on appeal.

Agreeing with the Seventh Circuit's findings, this court now addresses the sole question of whether the defendant raised the issue of causation in a timely manner. The court discusses the defendant's previous assertion in its motion to dismiss that the plaintiff's claim should fail because the plaintiff could not show the December 2012 appraisal caused loss. The court denies the defendant's motion, finding that the plaintiff plausibly alleged that the defendant caused harm to the ESOP. The court agrees with the plaintiff's argument that if the defendant had not approved the first appraisal value of $17.55 from December 2012, and had instead realized the stock's lack of value, it is plausible to suggest that the ESOP would not have used the valuation to purchase the stock at $17.55 in June 2013. Further, the defendant contends that it cannot be found liable for any harm to the ESOP because the stock purchase in June 2013 was based on the second trustee's approval, arguing that this approval was a superseding cause of the ESOP's injuries. The court declines to resolve this question on the instant motion to dismiss and finds this question better addressed in summary judgment.

Accordingly, the court denies the defendant's motion to dismiss.

Appvion, Inc. Retirement Savings and Employee Stock Ownership Plan v. Richards et al., No. 18-C-1861 (E.D.Wis., January 30, 2025).

Plaintiff Entitled to LTD Benefits Based on Plan Terms for Disability

DISABILITY BENEFITS

The U.S. District Court for the Western District of Washington declares the plaintiff disabled and eligible for long-term disability (LTD) benefits, in accordance with the plan's definition, following a prior denial.

Background

The plaintiff is a former director of a wealth management company who sought LTD benefits under an employer-sponsored insurance plan. The defendant is the insurance company that insures and administers the LTD benefits under the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plan offered LTD benefits to employees who met the plan's disability criteria. The plaintiff, a participant in the plan, had a history of chronic abdominal pain and had undergone various medical procedures, including a colonoscopy, hernia repair, appendectomy, hysterectomy and ovarian cystectomy.

The plaintiff submitted a claim for LTD benefits based on a recent flare-up of symptoms. The intensity of her symptoms required her to take time off work, and she reported feeling confined to her home due to the pain. Her medical providers attributed the pain to an ovarian cyst, which led to an ovarian cystectomy. The surgery was performed in September 2023, and if it had resolved the issue, she would have been cleared to return to full-time work by October 2023.

However, after the surgery, the plaintiff continued to experience pain. Nearly four weeks after her expected return-to-work date, her primary care physician noted that the plaintiff still suffered from severe pain, particularly when sitting, standing or walking. In January 2024, the primary care physician confirmed that the plaintiff's pain, of unclear origin, prevented her from completing a full eight-hour workday. The physician further explained that the plaintiff required time off work to pursue additional medical evaluation and treatment for her ongoing pain.

The plaintiff initially filed her LTD claim around August or September 2023, before her cystectomy surgery. After receiving the claim, the defendant gathered the plaintiff's medical records from various health care providers, covering the period from February 2023 to October 2023. The defendant then sought an independent review of the records by a physician consultant and referred the claim to a vocational rehabilitation consultant for an occupational analysis.

In December 2023, the defendant denied the plaintiff's claim based on the reports of the independent physician consultant and the vocational rehabilitation consultant. The vocational rehabilitation consultant classified the plaintiff's occupation as sedentary in nature. The independent physician consultant concluded that, as of September 2023, the plaintiff's functional limitations primarily involved sitting (up to four hours a day), standing (up to three hours a day) and walking (up to two hours a day). Based on these conclusions, the defendant determined that the plaintiff, with reasonable accommodations, was capable of performing the material duties of her occupation and did not meet the plan's definition of disability.

The defendant's decision did not address whether the restrictions outlined by the independent physician consultant were warranted beyond December 2023, nor did it consider the primary care physician's findings that the plaintiff could only sit for up to two hours a day and required a one-hour break every 30 minutes of sitting.

Court: U.S. District Court for the Western District of Washington

Decision: An insurance company improperly denied LTD benefits to the former director of a wealth management company whose medical conditions prevented her from sitting for more than four hours a day.

In response, the plaintiff filed an appeal, submitting a letter from her primary care physician stating that the plaintiff's pain prevented her from sitting for extended periods. The physician further explained that, due to her pain and the need for frequent breaks, the plaintiff could not perform a full-time job, even with a sit-stand option. Additionally, the physician noted that the plaintiff was unable to work part-time due to the severity of her pain.

After receiving the appeal, the defendant referred the claim to another independent physician for review. The new physician concluded that the restrictions and limitations imposed by the previous consultant were unsupported, citing a lack of documented ongoing treatment for the plaintiff. Although the plaintiff's primary care physician provided detailed records of ongoing treatment and reiterated the need for time off to pursue further medical care, the independent physician maintained that there was insufficient evidence to support the plaintiff's claim.

The plaintiff subsequently provided additional medical records from hospital visits and physical therapy notes from February to March 2024. Despite this new information, the independent physician's opinion remained unchanged, and the defendant upheld its denial of the claim. As a result, the plaintiff filed this lawsuit seeking LTD benefits.

Arguments and Discussion

The court reviews the determination de novo and concludes that the defendant improperly denied the plaintiff's LTD claim. The court begins by discussing its determination that the plaintiff is, in fact, disabled under the terms of the plan. It highlights a bright-line rule in the circuit: An employee who cannot sit for more than four hours in an eight-hour workday cannot perform sedentary work, which typically requires sitting for most of the day. The court notes that the defendant classified the plaintiff's job as sedentary and that even the independent physician concluded that the plaintiff could only sit for up to four hours a day. Based on the defendant's findings, the court holds that the plaintiff is disabled as a matter of law.

The court further notes that even if the bright-line rule did not apply or exist, the plaintiff would still meet the plan's definition of disability. Under the plan, a claimant is considered disabled if, during the elimination period and beyond, they are unable to perform the material duties of their occupation. The plaintiff was unable to perform the material duties of her sedentary job because she could sit for only 30 minutes at a time before needing to lie down for a one-hour break. Even with this accommodation, she could sit for only four hours a day. The court determined that, under these circumstances, it would take the plaintiff 12 hours to complete the equivalent of four hours of work.

The court also notes that the defendant ignored the plaintiff's primary care physician's multiple warnings that her restrictions made it impossible for her to work, even with the option to sit and stand, and that the facts confirmed the plaintiff could not complete the material duties of her job. As a result, the court concludes that the plaintiff's condition clearly extended beyond her elimination period of December 2023 and, thus, she was disabled under plan terms and improperly denied benefits by the defendant.

The defendant attempts to argue that the evidence weighs against the plaintiff for many reasons, including that the plaintiff's primary care physician's determinations lacked credibility because she began treating the plaintiff in July 2023 and because the plaintiff allegedly told her physician what to write in her various letters and reports. These arguments do not convince the court because they are not supported by the administrative record and draw unreasonable inferences.

Accordingly, the court grants the plaintiff's motion and declares that the plaintiff is disabled as defined in the plan.

Dime v. Metropolitan Life Insurance Co., No. C24-0827-JCC (W.D. Wash., January 29, 2025).

Additional Limited Discovery Ordered to Determine Health Plan Funding Status in ERISA Dispute

PREEMPTION

The U.S. District Court for the District of Maine denies the defendant's motion to dismiss in a claim for benefits after determining that additional limited discovery is required to determine whether the benefit plan is "self-funded" or "insured" for Employee Retirement Income Security Act (ERISA) preemption.

Background

The plaintiff is a former participant who sought coverage for prosthetic devices under his employee benefit plan. The defendant is the insurance company that administers claims under the plan. The plan is governed by ERISA.

The defendant was the plan's claim administrator for benefit determinations, but the plan was otherwise sponsored and administered by the plaintiff's employer. The plan documents explained that, generally, all health services and benefits must be medically necessary to be covered and specifically excluded from coverage are certain types of prosthetic appliances and devices, such as microprocessor prosthetic devices.

The plaintiff suffered from a knee dysfunction due to an above-knee amputation. He requested coverage for a microprocessor prosthetic device, as was recommended by his treating physician, and the defendant denied the coverage request. The defendant provided the plaintiff with a denial notice informing him that the plan did not cover the requested services, regardless of the reason the service was requested. In response, the plaintiff appealed the defendant's decision. The defendant upheld its determination on appeal.

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

Decision: A former health plan participant's claim for coverage for a prosthetic device may continue because additional discovery is needed to determine whether the health plan is self-funded and therefore exempt from a state insurance law that requires the plan to cover the device.

Arguments and Discussion

The plaintiff now brings a claim under ERISA for the recovery of benefits. As an initial matter, the plaintiff alleged that the plan was funded through an insurance policy that the defendant issued to his employer and, because the plan is insured, the defendant was required to pay for covered expenses in accordance with state law. The plaintiff now concedes that the plan's exclusionary language bars coverage of the requested microprocess prosthetic device.

Despite this language, the plaintiff asserts that the defendant is nonetheless required to cover the prosthetic device because the exclusionary policy violates a state insurance law. The state insurance law requires any insurance carrier to cover the prosthetic device determined by the enrollee's doctor to adequately meet the enrollee's medical needs. The plaintiff argues that the defendant insures the plan and, therefore, is governed by state insurance law and seeks a judgment ordering the defendant to cover the prosthetic medical device.

The defendant moves to dismiss the complaint, arguing that because the plan is self-funded by the plaintiff's employer and not insured by the defendant, the state insurance law is preempted by ERISA and does not govern the plan. The defendant contends that the plan's exclusionary language is valid because the state insurance law does not apply to the plan and, thus, the complaint should be dismissed because the plaintiff is not owed any benefits and fails to state a claim.

Generally, ERISA preempts all state laws relating to any employee benefit plan. However, the savings clause creates an exception to the general rule and allows states to enforce state laws that regulate insurance. The deemer clause creates a further exception to this rule. It states that no employee benefit plan shall be deemed to be an

insurance company or engaged in the business of insurance for the purpose of any state law that intends to regulate insurance companies or contracts. In previous rulings, the Supreme Court has limited the application of the deemer clause and has specified that whether the clause applies depends on if the health plan is *insured*—that is, if the employer funds benefits by buying a group health insurance policy from an insurance company—or *self-funded*—if the employer uses its own funds out of its general assets to pay benefits. If the plan is self-funded, it may not be deemed insurance or regulated by state insurance laws.

The main question before the court is whether the plan is self-funded. The court begins its analysis by referencing the plan's notice, which states that it is "self-insured" by the plaintiff's employer, and that the defendant does not insure the benefits described within the booklet. Further, the notice states that any references to insurance shall be read to indicate that the plan is self-insured. The court reasons that typically, when a written instrument contradicts the allegations within the complaint, the written instrument wins over the allegations. The court finds that this cannot be the case here because, though the plan's notice states that it is "self-funded," the plan is unclear. Specifically, the court notes that the notice states that although the defendant does not insure the plan, it nonetheless may use words that describe a plan insured by the defendant. Moreover, within the plan, there are definitions that could cause confusion as to the role of the defendant within the plan.

The court determines that without further discovery, it is unclear where the dispositive issue of the plan's funding status lands and, therefore, it cannot grant a motion to dismiss at this stage.

Accordingly, the court denies the defendant's motion to dismiss and orders limited discovery to determine the question of whether the plan is self-funded.

Gillespie v. Cigna Health Management Inc., No. 2:24-cv-00160-NT (D. Ma., January 27, 2025).

Order Removed to Federal Court Under ERISA Preemption Remanded to Superior Court

PREEMPTION

The U.S. District Court for the Central District of California determines that an order removed to federal court on the grounds of complete preemption under the Employee Retirement Income Security Act of 1974 (ERISA) should be remanded to the state superior court.

Background

The plaintiff is the assignee of various emergency medical groups whose physicians provided emergency medical services to the defendant's health care service plan subscribers. The defendants include health insurers and/or managed health care companies and service plans.

The plaintiff's emergency medical physicians provided services to members and subscribers of the defendants' health care service plans. When the physicians provided the emergency services, they did not have contracts with the defendants; rather, the physicians set their own reasonable rates and charges for the care they provided to the defendants' members. In effect, the physicians were out-of-network providers.

The plaintiff asserts that under the Emergency Medical Treatment and Labor Act (EMTALA) and the California Health and Safety Code, the physicians were obligated to deliver emergency services to all patients, regardless of their insurance coverage. However, the relationship between the physicians and defendants was governed exclusively by California statutory and contract law.

Additionally, the plaintiff claims that under California's Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), which sets required payment levels for out-of-network emergency providers, the defendants were obligated to compensate the plaintiff for the reasonable and customary value of services rendered by the physicians. The plaintiff alleges that the defendants underpaid and/or failed to pay for the emergency services provided by its physicians.

The plaintiff brings causes of action for (1) common law breach of implied contract, (2) common law open book accounting and (3) violation of the Unfair Competition Law. The plaintiff opted not to pursue any claims under ERISA, asserting that California law governs.

The defendants removed the case to federal court, citing (1) substantial federal question jurisdiction, (2) complete preemption under ERISA and (3) removal of a federal officer. The plaintiff now seeks to have the case remanded to state court.

Court: U.S. District Court for the Central District of California

Decision: A lawsuit alleging that several health insurers and insurance companies underpaid emergency medical physicians is remanded to state court because the defendants failed to satisfy both prongs required for complete ERISA preemption.

Arguments and Discussion

In general, a civil action filed in a state court, over which a district court has original jurisdiction, may be removed to federal court by the defendants. The defendants bear the burden of demonstrating that removal is proper. Complete preemption applies when a state law claim requires resolution of a substantial federal question.

The court begins its analysis by addressing ERISA preemption. The defendants assert that ERISA completely preempts the plaintiff's claims. Under ERISA, complete preemption grants federal subject matter jurisdiction over claims that typically arise under state law. Preemption applies when (1) the claim could have been brought under ERISA and (2) no independent legal duty exists based on the defendant's actions. Both prongs must be met.

For the first prong, ERISA Section 502 grants a right of action to participants or beneficiaries of a plan, the Secretary of Labor, employers of

participants and employee organizations that contribute to a multiemployer plan. Participants and beneficiaries can assign their rights to benefits under an ERISA plan to their health care providers, allowing providers to assert claims on their behalf.

The defendants argue that, despite the plaintiff's assertion that it does not base its claims on any assignment from beneficiaries, the complaint shows the existence of such assignments. The defendant claims that this allows the plaintiff to assert an ERISA claim based on the rights of participants and/or providers, effectively acting as a subassignee. The plaintiff counters that it does not hold derivative authority as an assignee and that any alleged assignments are irrelevant. The plaintiff argues that its claims stem from the defendants' actions toward third-party emergency providers and violations of California law, which are independent of ERISA.

The court agrees with the defendants that the plaintiff may have derivative standing under ERISA as a subassignee, but it finds that the defendants fail to prove the existence of any assignments. The defendants only provide evidence of a single claim related to one patient, where a physician noted obtaining an assignment. The court concludes that one assignment out of over 3,000 disputed claims does not demonstrate that the claim could have been brought under ERISA. The defendants further argue that the plaintiff's direct submission of claims and receipt of payments imply the existence of assignments under ERISA, suggesting that physicians could not have submitted claims and received payments without assignments. However, the court finds that this does not establish the existence of assignments for complete preemption under ERISA. The court concludes that the defendants fail to meet their burden of proof on the first prong and that the first prong remains unsatisfied.

Next, the court moves to the second prong, even though the defendants fail to meet the first prong. Since both prongs are necessary for complete preemption, the court notes that its analysis of the second prong would not lead to preemption. Courts have ruled that ERISA does not preempt claims based solely on the physician's independent relationship with the defendant. The plaintiff's complaint specifically states that the claims arise from the interactions between the physicians and the defendants, and the physicians disclaim and do not seek to assert any derivative claims that could be stated by a patient, including any claims under ERISA.

The defendants attempt to argue that some of the statutes the plaintiff relies on to establish independent legal duties do not apply to the defendants. Still, the court finds that the plaintiff's non-ERISA legal theories do not change the fact that the theories, as pleaded, do not implicate any duty under ERISA and, therefore, do not give rise to jurisdiction under complete preemption. Thus, the court finds that the defendants fail to demonstrate that the plaintiff could have brought its claim under ERISA.

Finally, the court next addresses the question of federal officer removal and substantial federal question jurisdiction. It finds that the defendants did not establish that the plaintiff is asserting any claims against them in their capacity as a federal medical organization and that the presence of a federal issue in a state case does not automatically confer federal question jurisdiction.

Accordingly, the court grants the plaintiff's motion to remand to the state superior court, finding the defendants fail to show ERISA complete preemption, federal officer removal and substantial federal question jurisdiction.

Health Care Justice Coalition CA Corp. v. UnitedHealth Group, Inc., et al., No. CV 24-04715-MWF (C.D.Cal., January 27, 2025).

Washington Update

Temporary Enforcement Policy for Missing Participants and Beneficiaries of Small Pension Plan Payments

On January 14, 2025, the Department of Labor (DOL) issued *Field Assistance Bulletin 2025-01 (FAB 2025-01)* to offer guidance on a temporary enforcement policy related to missing participants and beneficiaries in pension benefit plans. This guidance was issued to address the difficulties in locating missing participants and beneficiaries and ensuring that fiduciaries comply with the requirements of the Employee Retirement Income Security Act (ERISA) and participants and beneficiaries receive the benefits to which they are entitled.

Temporary Enforcement Policy

The temporary enforcement policy permits fiduciaries to pay the benefits of missing participants and beneficiaries, including uncashed checks, to a state unclaimed property fund provided that (1) the nonforfeitable accrued benefit is $1,000 and (2) the fiduciary complies with the following conditions.

1. The plan fiduciary concludes that transferring the participant's or beneficiary's retirement benefit payments to a state unclaimed property fund is a prudent choice.
2. The plan fiduciary has implemented a prudent program to locate missing participants in accordance with the DOL's best practices for pension plans but has been unable to find the participant or beneficiary.
3. The plan fiduciary selects the state unclaimed property fund of the state corresponding to the participant's or beneficiary's last known address.
4. The plan's summary plan description informs participants that retirement benefit payments for missing participants or beneficiaries may be transferred to an eligible state fund and provides the name, address and phone number of a plan contact for further information on the eligible state funds to which the benefits may be transferred.
5. The state unclaimed property fund qualifies as an "eligible state fund."

Eligible State Fund Qualification Requirements

In order for the state unclaimed property fund to be an eligible state fund, the state fund must:

1. Serve as the custodian of the funds for the benefit of the affected participants, beneficiaries and their heirs, allowing claims to be made and paid indefinitely, regardless of when the state received the unclaimed property
2. Not reduce the transfer amount by any fees or charges, ensuring that the approved claimant receives no less than 100% of the amount reported and remitted by the fiduciary
3. Maintain or ensure the maintenance of a searchable website that reliably displays, at no charge, the name of the missing participant or beneficiary and the name of the plan on the search results page as well as allows for an electronic claims process
4. Offer the public the ability to inquire about unclaimed property through physical mail, electronic mail and telephone
5. Participate in the National Association of Unclaimed Property Administrators' MissingMoney.com website or a similar noncommercial unclaimed property database managed by the National Association of State Treasurers, Inc.

continued on next page

Washington Update

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6. Provide streamlined processing for small claims, such as those of $1,000 or less
7. Conduct a diligent search at least annually for updated addresses of missing participants and beneficiaries with amounts exceeding $50, and, upon finding an updated address, notify the owner in writing that the state fund is holding their money
8. Allow a plan whose fiduciary has transferred unclaimed property to the state to pay a reappearing participant or other payees directly and subsequently seek reimbursement from the state
9. Participate in the States' Unclaimed Property Clearing House, as managed by the National Association of State Treasurers, Inc.

The temporary enforcement policy aims to provide a solution for pension plans dealing with missing participants and beneficiaries and, at this time, the DOL continues to develop long-term solutions, such as the Retirement Savings Lost and Found database and additional guidance on transferring missing participants' and beneficiaries' benefits to state unclaimed property funds.

FAB 2025-01 can be accessed at www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2025-01. The DOL's best practices for pension plans are available at www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/retirement/missing-participants-guidance/best-practices-for-pension-plans.

Court Vacates Prior Dismissal

continued from page 49

unenforceable by the court, the court finds that the case law is indeed binding. The court agrees that the controlling case law renders individual arbitration provisions unenforceable when an ERISA claim is brought on behalf of the ESOP. Since the plaintiffs' claims are brought on behalf of the plan members, the individual arbitration agreements in both the employment agreement and the ESOP are unenforceable. Enforcing them would prevent the effective vindication of statutory rights. Accordingly, the court grants the plaintiffs' motion for reconsideration and vacates its previous order granting dismissal.

Because dismissal was previously granted based on the arbitration agreements, the court did not address the defendants' Rule 12(b)(6) arguments. The defendants have now renewed these arguments, claiming that even if the arbitration agreements are unenforceable, the plaintiffs' claims should still be dismissed for failing to meet the plausibility standard. In their complaint, the plaintiffs allege a breach of fiduciary duty, claiming that the defendants bought back company stock at a deflated value despite the company's increasing value.

To state a claim for breach of fiduciary duty, plaintiffs must show that the defendants were fiduciaries that acted in their capacity as fiduciaries and violated their duties. The plaintiffs allege that the defendants were fiduciaries with respect to the ESOP because they exercised discretionary authority in the management of such plan or disposition of its assets and had discretionary authority in the administration of the plan for all practical purposes. The plaintiffs further alleged that the defendants breached their fiduciary duties by failing to adequately investigate the stock buyback, participating in a self-interested deal and causing the ESOP to sell its company stock below fair market value. The court disagrees with the defendants and finds that the plaintiffs have alleged enough facts to make their claim plausible. Regarding the plaintiffs' allegations of the defendants engaging in a prohibited transaction under ERISA, the court finds that the plaintiffs have also adequately alleged this claim, as the facts supporting the breach of fiduciary duty claim also support the prohibited transaction claim.

Accordingly, the court denies the defendants' motion to dismiss, finding that the plaintiffs' claims met the plausibility standard of Rule 12(b)(6).

Best et al. v. James et al., No. 3:20-cv-299-RGJ (W.D.Ky., February 3, 2025).

Gordon Hartogensis
Former Director,
Pension Benefit
Guaranty Corporation,
Washington, D.C.

Former PBGC Director Receives 2025 Public Service Award

Gordon Hartogensis, former director of the Pension Benefit Guaranty Corporation (PBGC), was honored with the 2025 Public Service Award during the International Foundation's annual Washington Legislative Update event in May.

Since 1979, the International Foundation's Public Service Award has recognized those who have publicly demonstrated acts of awareness and concern or those who have made personal contributions beneficial to participants of employee benefit plans and the employee benefits industry.

Hartogensis served as PBGC director from 2019 to 2024. During his tenure, he worked on addressing the multiemployer pension crisis and implemented the Special Financial Assistance (SFA) program as part of the American Rescue Plan Act of 2021. Hartogensis has a background in technology and investment, having founded and led several companies before his role at PBGC.

"Over the years, an esteemed group of individuals has been honored with the Public Service Award, and this year is no exception," Julie Stich, CEBS, Vice President of Content at the International Foundation, said in a prepared statement. "Leadership from Hartogensis provided relief to financially distressed multiemployer defined benefit pension plans, protecting the retirement benefits of approximately two million workers and retirees."

Todd G. Helfrich (left), International Foundation President and Chair of the Board, presents the 2025 Public Service Award to Gordon Hartogensis, former director of the Pension Benefit Guaranty Corporation.

Presenter David Wasserman, senior editor and elections analyst for *The Cook Political Report with Amy Walter* and NBC contributor, discussed the political landscape in 2025 and beyond during the Washington Legislative Update in May.

Gain Expert Guidance and Connect With Peers at the 71st Annual Employee Benefits Conference

With more than 120 sessions presented by over 200 experts, the 71st Annual Employee Benefits Conference provides the information you need to navigate complex challenges and keep your benefit plans compliant and competitive.

This year's conference takes place November 9-12, 2025 in Honolulu, Hawai'i. Keynote speakers include a TV chef, an expert on collaboration, a nationally known economist, and a technology and turnaround executive turned executive coach. Following the keynote sessions, you'll have your choice of sessions ranging from basic to advanced levels in ten focused tracks, plus the opportunity to meet peers from around the country and access an exhibit hall full of 230 service providers and vendors.

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

Visit the Hospitality Hub

The Hospitality Hub returns at the Annual Employee Benefits Conference. At the Hub, you can get your questions answered about the International Foundation and the Wellness Alliance, shop at the Foundation store, charge your device and use a workstation. Perks beginning on Monday, November 10 include complimentary headshots, the Relaxation Station and snack breaks.

Sunday, November 9
Overcoming Adversity
Andrew Zimmern
TV Personality,
Chef and Author

Monday, November 10
Get Big Things Done: The Power of Connectional Intelligence
Erica Dhawan
Collaboration Expert,
Author and Entrepreneur

Tuesday, November 11
Economic Update
Marci Rossell
Expert Economic Forecaster,
Former CNBC Chief Economist
and Co-Host of *Squawk Box*

Wednesday, November 12
Red Shoes Living, Igniting Human Potential
Lonnie Mayne
Founder, CEO and Author
Red Shoes Living, Inc.

Benefit Basics for Plan Participants

Are you looking for resources to educate your plan participants about their employee benefits? The Benefits Basics for Plan Participants toolkit includes videos and customizable resources that you can easily share with plan participants and employees.

Current topics include:

- Flexible spending accounts (FSAs)
- Health savings accounts (HSAs)
- Tips for picking the right health insurance plan
- Compound interest and retirement savings
- The value of retirement plans
- Voluntary benefits.

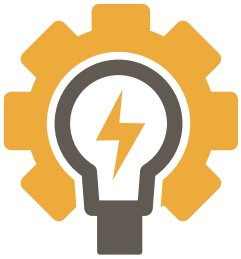
Visit www.ifebp.org/toolkits to access this toolkit and others.

member profile

Member of the Moment
Neal Lauzon

Serving

Trustee for the International Brotherhood of Electrical Workers (IBEW) Local 441 defined benefit pension plan and defined contribution retirement plan and chairman of the Local 441 Joint Apprenticeship and Training Committee (JATC).



By Day

IBEW Local 441 Business Manager in Orange County, California

Biggest Reward of Serving as a Trustee

"The ability to effect positive change for our members for their future. They're out there in the field building communities and working their jobs every day, and they're relying on the individuals who they put in these positions to represent their best interests. It is a big reward to know that what we do at the table really sets people up for a good retirement."

Biggest Challenge

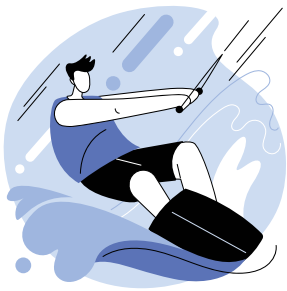
"Coming from the field as a journeyperson, you're kind of drinking from the fire hose when it comes to becoming a trustee and learning the basics of these pension plans—from our fiduciary responsibility to trying to understand the markets."

Favorite International Foundation Educational Program

"The Trustees Masters Program (TMP). I took it in November, and it really opened my eyes on another level. The interaction and the ability to work with other trustees on a more personal level instead of sitting in a class with a more one-way conversation. It was pretty awesome."

Advice for New Trustees

"Do a lot of listening and not a lot of talking. It's mostly about listening and absorbing and taking the classes. That's been a huge help."



In My Spare Time

"I love spending time with my family out at Lake Mohave or Lake Havasu. We do some water sports—wake boarding and knee boarding. I ride motocross on some weekends and play golf on other weekends."

plan | ahead

July 2025

14-15 Fraud Prevention Institute for Employee Benefit Plans
Chicago, Illinois
www.**ifebp.org**/fraudprevention

14-18 Certificate in Global Benefits Management
Chicago, Illinois
www.**ifebp.org**/globalcertificate

14-19 Employee Benefits Courses and Certificates
Chicago, Illinois
www.**ifebp.org**/benefitscourses

15-16 Public Plan Trustees Institute—Level I
Chicago, Illinois
www.**ifebp.org**/public

15-16 Understanding Negotiated Employee Benefits
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/negotiatedemployeebenefits

21-23 CONNECT Global Employee Benefits and Workforce Strategies Summit
Dallas, Texas
www.**ifebp.org**/CONNECT

22-23 Designing Curriculum to Close the Skills Gap
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/skills-gap

August 2025

18 Annual Wellness Summit—Preconferences
Austin, Texas

19-21 Annual Wellness Summit
Austin, Texas
www.**ifebp.org**/annual-wellness-summit

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

September 2025

14-17 44th Annual ISCEBS Employee Benefits Symposium
Minneapolis, Minnesota
www.**ifebp.org**/symposium

29-30 Collection Procedures Institute
Monterey, California
www.**ifebp.org**/collections

October 2025

6-8 Certificate in Canadian Benefit Plans
Austin, Texas
www.**ifebp.org**/canadacert

6-11 Employee Benefits Courses and Certificates
Austin, Texas
www.**ifebp.org**/benefitscourses

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

[schedule subject to change]

71st ANNUAL
Employee Benefits Conference

November 9-12, 2025
Honolulu, Hawai'i
Virtual option available

In-Person Preconferences:
November 7-9
www.**ifebp.org**/usannual

New Trustees Institute—Level I: Core Concepts
November 7-9
www.**ifebp.org**/newtrustees

Trustees Institute—Level II: Concepts in Practice
November 8-9
www.**ifebp.org**/trusteeslevel2

Trustees Masters Program (TMP)
November 8-9
www.**ifebp.org**/tmp

TMP Advanced Leadership Summit
November 9
www.**ifebp.org**/tmpsummit

January 2026

11 Institute for Apprenticeship, Training and Education Programs—Preconference
San Juan, Puerto Rico

12-14 Institute for Apprenticeship, Training and Education Programs
San Juan, Puerto Rico
Virtual option available
www.**ifebp.org**/apprenticeshipinstitute

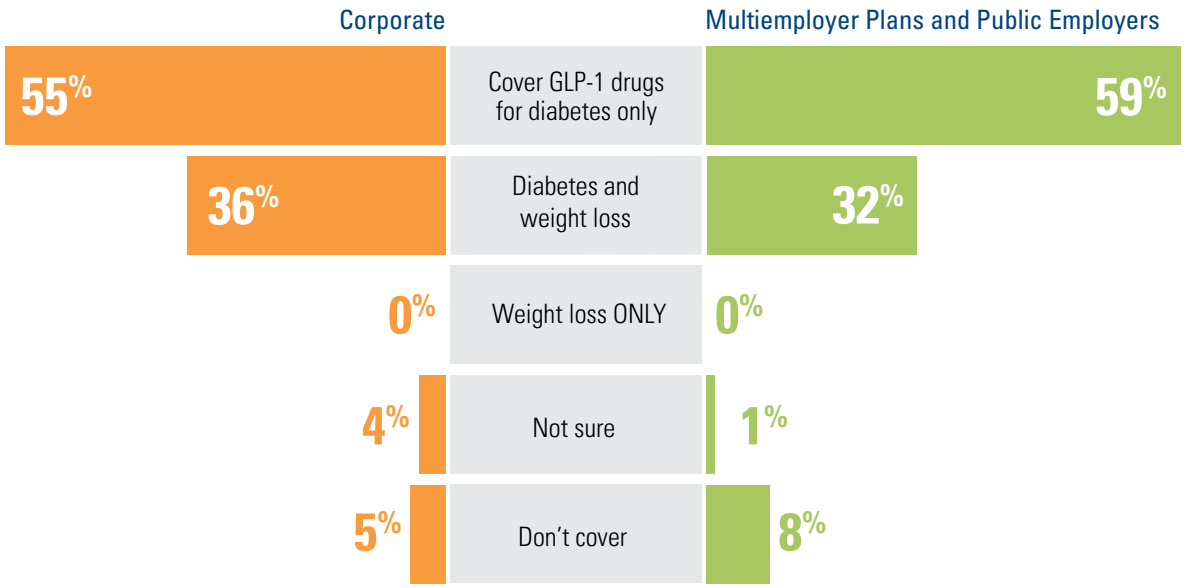
20 35th Annual Health Benefits Conference & Expo—Preconference
Ponte Vedra Beach, Florida

20-22 35th Annual Health Benefits Conference & Expo
Ponte Vedra Beach, Florida
www.**ifebp.org**/hbce

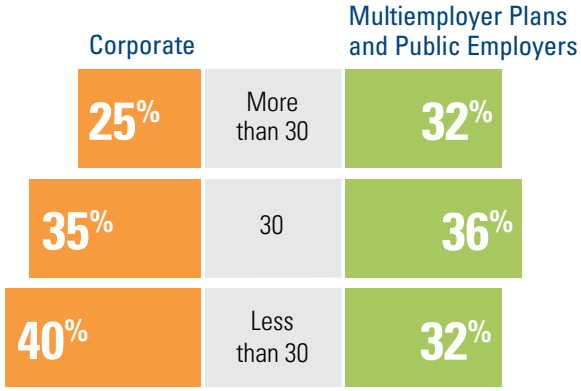
benefit fringe | GLP-1 drug coverage trends

Claims for coverage of glucagon-like peptide-1 (GLP-1) drugs for weight loss represent a growing share of health care claims, a recent survey from the International Foundation shows. The average share of total annual claims attributed to GLP-1 drugs for weight loss rose to 11.2% in 2025 for survey respondents from multiemployer and public employer plans, compared with 9.6% in 2024. Claims for GLP-1 drugs for weight loss represented an average share of 10.5% of annual claims among corporate respondents, up from 8.9% in 2024. The International Foundation has surveyed employers and plan sponsors about their coverage of GLP-1 drugs three times since 2023, and the surveys continue to show sustained interest in the drugs. Visit www.ifebp.org/GLP2025 to view the full survey report.

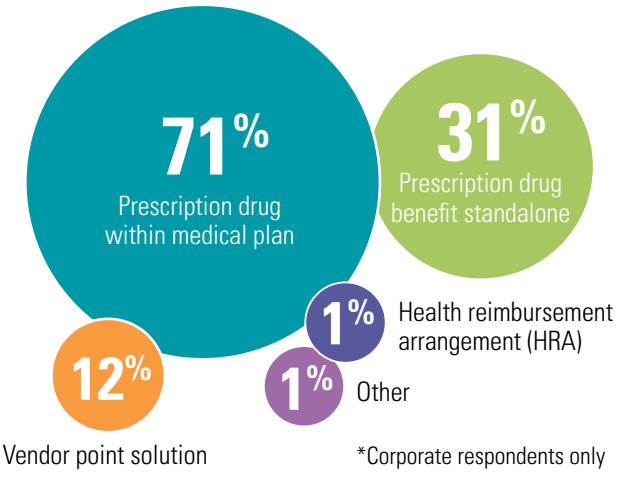
Coverage of GLP-1 Drugs



Minimum Body Mass Index (BMI) Requirement for GLP-1 Eligibility



Methods for Covering GLP-1 Drugs*



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- Charting the Course: Key Decision Points and the Path to Merging Multiemployer Plans
- Best Practices in Trustee Processes and Oversight
- Fiduciary Responsibility Basics
- Communicating With Plan Participants—Case Study Examples of Success
- Health Hacks—Best Practices in Participant Health Literacy
- Cryptocurrency: The Impact of Deregulation for Investments
- Institutional Investing 101
- Defined Contribution Plan Risk—Options to Minimize and Mitigate
- Mental Health Parity—Audits of Public Sector Plans
- Navigating a Challenging Public Sector Environment
- Emerging Technologies in Using Artificial Intelligence in Your Apprenticeship Programs
- Accountants: Accounting and Auditing—Key Updates and Insights for 2025
- Attorneys: Changes to the Legal Landscape Impacting Employee Benefit Plans

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