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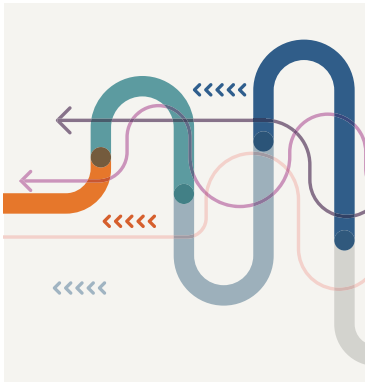

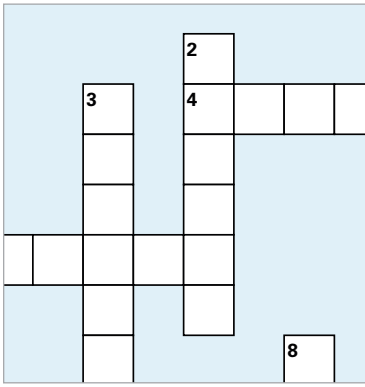

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contributors

One of the best ways for employee benefit plans to prepare for a potential government investigation—whether random or targeted—is to conduct regular self-audits, attorneys **Amy Pocino Kelly, Dan R. Salemi** and **Rachel Mann** contend. The authors identify common areas of investigation by the Department of Labor (DOL) and Internal Revenue Service (IRS) as well as discuss changes contained in the SECURE 2.0 Act of 2022 that affect self-audits. Pocino Kelly is the deputy practice leader in the employee benefits and executive compensation practice at Morgan, Lewis & Bockius LLP. Salemi is a partner in the practice and Mann is an associate.

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As the United States experiences a heavy construction boom, multiemployer retirement plans may consider temporarily loosening suspension of benefits rules to incentivize retirees to return to work. Attorney **Michael Ledbetter, CEBS**, a partner with Ledbetter Partners LLC, and actuary **Pierce Martin, EA, MAAA**, a consulting actuary with United Actuarial Services, explain that this allows retirees to earn the same wage and benefit package as other collectively bargained employees while also collecting their retirement benefits. However, these changes must be navigated with caution to ensure compliance with federal law and minimize any negative impacts to the plan.

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Employee Retirement Income Security Act (ERISA) plans can help their participants find affordable housing through the creation of a housing assistance fund, but few plans have implemented such programs. Attorney **John R. Harney**, an adjunct professor of law at the Boyd School of Law at the University of Nevada at Las Vegas, describes the affordable housing challenges that many workers face and provides considerations for setting up a fund. Harney has more than 35 years of experience representing multiemployer pension and welfare plans.

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Changing conditions in the real estate market mean it may be a good time for pension funds to rethink, rationalize and adapt their real estate investments, writes **David Twist**, a managing senior research analyst with Alan Biller and Associates. Twist describes the attributes of private real estate equity investments, analyzes how they are valued and offers considerations for pension funds evaluating their real estate allocations.

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benefit basics | navigating health plan funding options

As the average annual premium for employer-sponsored health plans continues to rise, many employers and plan sponsors may explore self-insured and hybrid models as alternatives to fully insured plans. Racquel Maye, EA, FSA, founder of HR Transformation Consulting Group, discusses the basics of each model and identifies some of the benefits and disadvantages.

Racquel Maye, EA, FSA
Founder,
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Fully Insured Plans

In a fully insured plan, the employer pays a fixed premium to an insurance carrier, which covers anticipated claims, administrative expenses and the carrier's profit margin. The insurance company assumes the financial risk of covering employees' health care claims. Advantages include the following.

- **Cost predictability:** The fixed premium remains constant regardless of actual claims, thereby aiding effective budgeting and financial planning.
- **Risk mitigation:** The insurance carrier absorbs the risk of higher-than-expected claims, protecting the employer from unexpected financial burdens.

Disadvantages may include the following.

- **Higher costs over time:** Fixed premiums include the carrier's profit margin and administrative fees, which may result in higher overall costs compared with other models, especially if claims are consistently lower than expected.
- **Limited flexibility:** Plan sponsors have little control over plan design and cannot customize benefits to meet the specific needs of their workforce since plans are standardized by the carrier.
- **Reduced transparency:** Employers typically have limited access to claims data, making it difficult to analyze trends or implement targeted wellness programs.
- **State-mandated benefits:** Fully insured plans are subject to state regulations and mandated benefits, which is especially challenging for multistate employers.

Self-Insured Plans

With a self-insured plan, the plan sponsor assumes the financial risk of providing health care coverage, directly funding employee medical claims as they occur, and the administrative services are often outsourced to a third-party administrator (TPA). The insurance carrier's margin is typically absent in self-insured models, providing potential cost savings, but plans no longer have the financial buffer that a fully insured plan offers.

Advantages of this model include the following.

- **Flexibility:** Employers have greater flexibility in plan design since they don't have to adhere to the standard plan offered by the insurer.
- **Potential cost savings:** Without paying for the insurance carrier's profit margin or state-mandated benefits, plan sponsors may experience lower overall costs. If claims are lower than expected, the employer retains the unused funds.
- **Access to data:** Self-insured plans can more easily get detailed claims data, enabling better insights into employee health trends and opportunities to implement wellness initiatives that target specific health issues impacting the population.
- **Uniform benefits:** Self-insured plans are governed by the Employee Retirement Income Security Act (ERISA) and can establish one set of benefits because ERISA preempts state insurance laws.

However, disadvantages to be considered include the following.

- **Financial variability:** The plan sponsor bears the risk of fluctuating claims, which

can lead to unpredictable costs and potential financial strain, especially in years with high claims.
- **Regulatory complexity:** While not subject to state insurance regulations, self-insured plans must comply with federal regulations such as ERISA.
- **Cash flow strain:** Employers need to have sufficient reserves to cover high-cost claims, which could create financial strain, especially for smaller organizations.
- **Administrative burden:** Managing a self-insured plan involves significant administrative responsibilities, often requiring a TPA to handle claims processing and compliance, which adds costs.

Level-Funded Arrangements

A hybrid model, known as a level-funded arrangement, combines elements of both fully insured and self-insured plans. In this setup, the employer pays a fixed premium to the insurance carrier. If actual claims are lower than expected, a portion of the surplus is returned to the employer; if claims are higher, the carrier absorbs the excess costs. Like self-insured plans, these plans are subject to ERISA.

Consider the following advantages of this model.
- **Balanced risk and reward:** This arrangement offers cost predictability while providing an opportunity for employers to benefit from lower-than-expected claims.
- **Incentive for cost management:** Both the employer and insurance carrier are motivated to manage health care costs effectively to achieve potential savings. The carrier's profit potential also is limited by the surplus-sharing structure, which motivates the carrier to set premiums more closely aligned with expectations for claims experience.
- **Simplified administration:** Administrative responsibilities are largely handled by the insurance carrier, reducing the employer's workload compared with a self-insured plan.
- **Predictable budgeting:** Fixed premiums give the plan greater predictability for budgeting health care expenses.

Disadvantages include the following.
- **Limited savings potential:** Although employers may receive a portion of the surplus when claims are lower than expected, the carrier retains a significant share.
- **Shared incentives may be uneven:** While the carrier is incentivized to set premiums close to expected claims, the surplus-sharing structure may still prioritize the carrier's profit margins over maximizing cost recovery for the plan sponsor.
- **Complexity in surplus calculations:** Determining the surplus and how much is returned to the employer may lack transparency, leading to potential disputes or misunderstandings.
- **Restricted flexibility:** Employers have less control over plan design compared with self-insured plans.
- **Limited access to data:** Employers may not have the same level of detailed claims data as with a fully self-insured plan.

Making a Switch

With self-insured or level-funded arrangements, premiums and costs are more directly tied to a plan sponsor's own claims experience rather than a community-wide rate used with fully insured plans. However, if the employer is a large enough group, a fully insured employer will be experience rated. The potential for savings in these models is enticing, especially for organizations that are confident in the health of their workforce. The risks associated with fluctuating claims and the possibility of large, unexpected medical expenses are important factors to consider. Without the risk-spreading benefit of community rating, a single high-cost claim could significantly impact a plan sponsor's financial health.

Shifting away from a community-rated fully insured plan requires balancing the potential for savings with the need for financial protection against large claims. This is where stop-loss insurance and other cost-management strategies become crucial.

Ultimately, the decision to leave a community-rated fully insured plan must be made with a clear understanding of the risks and rewards, as well as a strategic plan for managing health care costs and protecting against potential downsides. It is essential to consider the three primary cost components the employer should be prepared to cover in the long term:

1. **Claims:** The expenses incurred from employees' medical services.
2. **Administrative expenses:** Costs associated with managing the health plan, including claims processing and compliance.
3. **Risk protection costs:** This is paid as either (1) the profit margin retained by the insurance provider in the

case of a fully insured plan or (2) stop-loss insurance premiums, as explained later in this article, applicable for self-insured plans.

The Role of Stop-Loss Insurance

Stop-loss insurance is a key consideration for employers transitioning to a self-insured model. This type of coverage is designed to protect plan sponsors from the financial strain of catastrophic claims by setting a limit on how much the employer is responsible for paying.

There are two primary types of stop-loss insurance.

- **Specific stop-loss:** Protects against individual high-cost claims. For example, if one employee incurs a large medical bill, the policy kicks in once the cost exceeds a predetermined threshold (e.g., $50,000).
- **Aggregate stop-loss:** Protects against the total amount of claims exceeding a certain percentage of expected costs across the entire group of covered employees.

Stop-loss insurance can protect an organization against the crippling effects of a single high-cost claim, but it adds an expense to the employer's health care budget.

The Importance of Cost Control

If active steps are not taken to control expenses—such as promoting wellness programs, encouraging preventive care and educating employees on cost-effective health care choices—the likelihood of higher-than-expected claims increases, reducing the savings potential for both self-funded and level-funded arrangements. Employees who do not receive guidance on managing chronic conditions or choosing in-network providers may overutilize expensive medical services, driving up the overall claims experience.

Though the insurance carrier in a level-funded arrangement may absorb the excess costs in the short term, it will eventually raise premiums to compensate for the higher claims experience. As a result, any potential savings from a surplus will be overshadowed by rising premiums over time, eroding the key feature of the level-funded model—the opportunity to recoup a portion of the surplus if claims are lower than expected.

Tips for Employers Considering a Switch

Before making the leap from a fully insured plan to a self-insured or level-funded arrangement, plan sponsors must carefully assess their readiness for this significant change. Here are some critical tips for organizations considering a switch.

1. **Conduct a financial risk assessment:** Understand your organization's risk tolerance by conducting a financial analysis of your cash reserves and claims history.
2. **Obtain leadership buy-in:** Leadership buy-in ensures that decision makers are committed to supporting the organization through the potential fluctuations in claims costs and the added complexities of managing the plan.
3. **Evaluate stop-loss coverage options:** If self-insured, make sure you understand the types of stop-loss insurance available and whether they adequately protect your organization from catastrophic claims.
4. **Partner with a knowledgeable broker or consultant:** A broker experienced in self-insured and hybrid models can guide you through the transition, help you evaluate plan options and ensure compliance with health care regulations.
5. **Engage employees early:** Communicate with employees about potential changes to their health plans. Employee buy-in is essential for the success of any health plan, so provide clear information about how the new plan will work and any benefits it offers.
6. **Plan for compliance:** Self-insured plans come with additional regulatory requirements, such as compliance with ERISA. Ensure that you have the necessary resources to manage these responsibilities when switching to a self-insured plan.

By following these guidelines, plan sponsors can make a more informed decision and set themselves up for success when switching to a new health plan model.

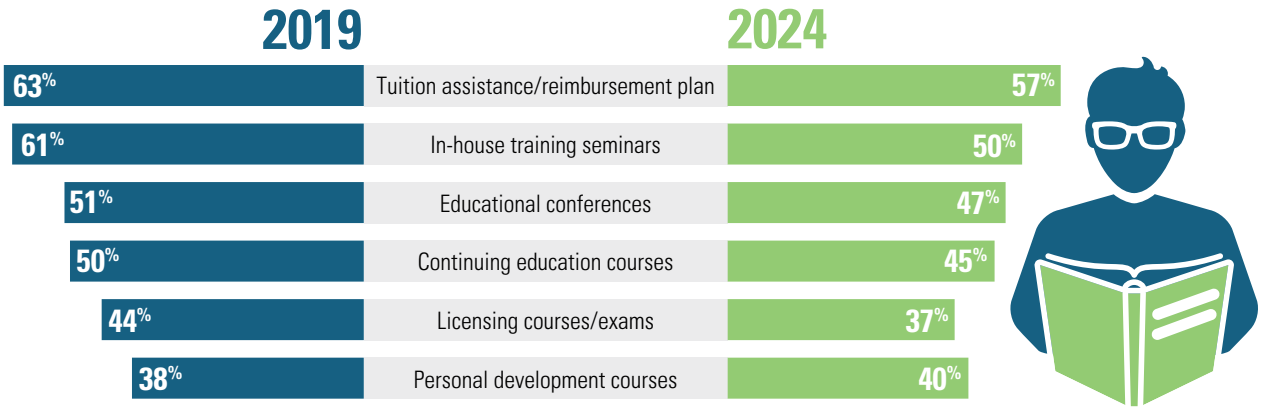
Conclusion

Selecting the appropriate health plan funding arrangement is a complex decision that requires careful consideration of an organization's financial stability, risk tolerance and employee needs. While fully insured plans provide cost predictability and risk mitigation, self-insured and level-funded models offer potential savings but come with the responsibility of managing health care costs. Ultimately, the key to success in any health plan funding arrangement lies in proactive management, employee engagement and a commitment to cost-saving strategies.

quick look | employer help for hitting the books

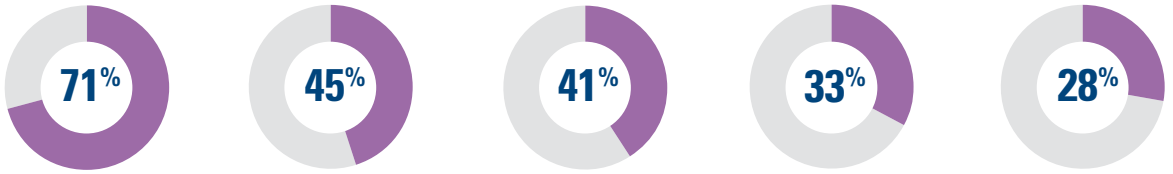
Employees who want to further their education are likely to find some form of assistance—such as tuition reimbursement programs or personal development courses—from their employer, according to a recent survey from the International Foundation of Employee Benefit Plans. *Education Benefits: 2024 Survey Report* revealed that 92% of responding corporate and public employer organizations provide some type of educational benefit. The survey received 365 completed responses and is available to download at www.ifebp.org/edubenefits2024. Survey report highlights include the following.

Types of Educational Benefits Offered*



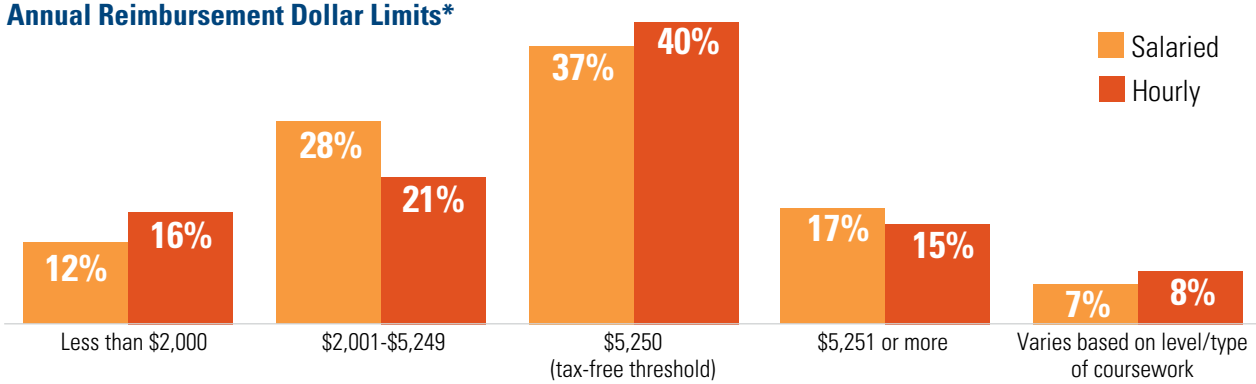
*Respondents were asked to select all that apply, and only the top six benefits offered are displayed.

Five Most Common Tuition Reimbursement Program Restrictions*



*Respondents were asked to select all that apply, and only the top five limitations are displayed.

Annual Reimbursement Dollar Limits*



*Among organizations that offer tuition reimbursement to full-time employees and have a fixed annual dollar amount limitation.

benefit trends | student loan assistance programs

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

When Hillcrest Educational Centers started offering student loan repayment assistance benefits in 2017, the Massachusetts nonprofit wanted to boost its standing as an employer of choice while also helping its employees pay off their debt.

Eight years later, the benefit remains an important differentiator, said Michele Morin, Hillcrest's vice president of human resources. "When we attend job fairs or conduct interviews, we are still one of very few employers in our area to offer a student loan paydown program. Standing out in the crowd is vital given the current challenges with staffing vacancies that many employers seem to be experiencing these days," she said.

A recent report from the International Foundation of Employee Benefit Plans reveals that many employers view student loan benefits in the same light, with attracting and retaining employees among the top reasons for offering student loan assistance programs. The report—*Education Benefits: 2024 Survey Report*—reveals trends in student loan repayment assistance programs in addition to tuition reimbursement programs among corporate and public employers. Overall, the survey received 365 responses.

Background

Student loan assistance benefits have made gains in popularity as both the number of people with debt and the amount of debt has grown.

About 18% of all U.S. adults owe money on outstanding student loans, according to a 2023 Federal Reserve report.[1] A recent *Forbes* article placed the national average student loan debt at $28,950 and the national average federal student loan debt at $35,210.[2] Debt affects workers across all age groups.

Student Loan Assistance Offerings

The International Foundation report revealed that the percentage of organizations offering student loan repayment assistance more than tripled from 4% in 2019 (the last time the survey was conducted) to 14% in 2024. In addition, nearly one in five (18%) employers is considering offering student loan repayment assistance. Although the percentage of organizations offering student loan assistance is growing, it is still relatively small.

Organizations can choose from a variety of student loan assistance programs. About half of employers offer tax-free student loan payments (in compliance with the tax-free threshold of $5,250 per calendar year), and a quarter offer after-tax student loan payments by the employer (treated as compensation/income).

"It is a success in terms of making a difference for a few employees in reducing their student loans. It has not had widespread impact on our employee population. Overall, it does contribute to a positive impression of the benefit package we offer employees."

Lorraine Serva
Chief People Officer
SDI
Jacksonville, Florida

Among organizations that offer student loan assistance, nearly all provide it to full-time salaried employees, and about seven in ten organizations offer it to full-time hourly employees. Roughly a quarter offer student loan assistance to part-time employees regardless of exempt status.

Hillcrest, which provides care, treatment, education and other services to youth ages six to 21 who have unique behavioral learning needs through residential and day school programs, employs about 550 people. The organization surveyed staff to gauge interest before launching the program. The nonprofit works with a vendor to administer the benefit. Staff must be a full-time employee but can participate 90 days after hire. Contributions range from $125 to $750 per quarter based on the employee's position within the agency.

SDI, a digital supply chain services firm based in Jacksonville, Florida, allows its employees to cash in a week of paid time off each year, and the company pays the student loan lender directly with the proceeds. SDI has offered the benefit

for three years and this year began offering a program under which it will match employees' student loan payments with a contribution to their 401(k) account.

Success Factors

When asked how they measure the success of their student loan programs, about four in ten organizations responding to the International Foundation survey said they use engagement measures as well as retention or utilization rates.

"We track how many staff are participating in the program and the amount of money we have paid toward their student loan debt. These numbers have been reported to staff at our semiannual all-staff meetings. It's been a while since we've crunched these numbers and analyzed them. We should consider conducting an analysis that's focused on the impact of this benefit on retention," Morin said.

"Initially, when we did a survey in 2017, we had some comments about the student loan paydown program not benefiting certain staff, but these comments were very small in number. The key here is to balance out your benefit offerings and make sure that you have offerings in place that are advantageous for staff based on their interest, importance and need."

Michele Morin
Vice President of Human Resources
Hillcrest Educational Centers
Pittsfield, Massachusetts

Lorraine Serva, who is SDI's chief people officer, said very few of the company's 400 employees use the student loan benefits. The company measures success by the "buzz" it receives—whether new employees mention it in new-hire surveys as a reason for joining the company and whether employees mention it in the annual engagement survey.

A survey by American Student Assistance (ASA) found that 86% of employees would stay with an organization for five years if the organization helped them pay off their loans. With the average cost to hire a new employee estimated at $4,700 by the Society for Human Resource Management (SHRM), employers may see a return on investment if workers stay with the organization because of the student loan benefit.

Potential for Resentment?

Offering student loan repayment assistance can create goodwill between employers and employees, but it has the potential to create dissatisfaction among employees who can't use the benefit. In the International Foundation survey report, two of the top four challenges cited by organizations that don't offer student loan assistance programs were resentment from workers who already paid off their loans (34%) or from those who have ineligible loan debt (30%). However, only 13% of organizations that offer student loan repayment assistance cited resentment from those two groups of workers as a challenge to offering the benefit—indicating that the perception of a negative impact may be worse than the actual impact.

Conclusion

Demand may be growing for student loan assistance programs. Research conducted by Employee Benefit News (EBN) found that 18% of employees want their employer to offer student loan financial assistance or repayment programs, and another 18% would like their employer to match their student loan payment with a contribution to their 401(k).[3]

About the Survey

Education Benefits: 2024 Survey Report included responses from corporate and public employer organizations in the databases of the International Foundation and the International Society of Certified Employee Benefit Specialists (ISCEBS). International Foundation members can visit www.ifebp.org/edubenefits2024 to view a copy of the report.

Endnotes

1. Federal Reserve. *Economic Well-Being of U.S. Households in 2023*.
2. *Forbes Advisor*. "2025 Student Loan Debt Statistics: Average Student Loan Debt."
3. *Employee Benefit News*. "The top benefits employees are seeking in 2025."

what's working | designing GLP-1 drug coverage

by | **Kathy Bergstrom, CEBS**

As the hype about antiobesity medications fueled more member requests for the medications, a New York health and welfare fund has embarked on a new program to help manage costs and improve member outcomes.

The Laborers' Local 157 Health Benefits Fund in Schenectady, New York started a new coverage program for glucagon-like peptide-1 (GLP-1) drugs in July 2024. With brand names including Zepbound® and Wegovy®, GLP-1s were initially used to treat diabetes but are now approved by the Food and Drug Administration (FDA) for weight loss.

Many health plan sponsors are weighing the potential health benefits for their members against the prospect of significant costs in their decisions about how to cover these drugs.

Coverage Challenges

Previously, the Local 157 fund had covered only gastric bypass surgery for weight loss, but it began covering GLP-1 drugs for weight loss in 2021 under its participation in an advanced utilization management program offered by its pharmacy benefit manager (PBM). The utilization management program dictated that GLP-1s would be covered for weight loss if it was a medical necessity and based on FDA parameters. The fund then enrolled in the first weight-management program offered by the PBM. That program was enhanced later in the same year.

At that time, only two injectable drugs were available. Utilization was low and mostly driven by doctor recommendations. "It was a slow trickle for us," said Michael P. Brady, administrator of the Local 157 benefit funds.

However, plan members who took the drugs were experiencing some challenges. Supply of certain brands became an issue as usage started to pick up. Some of the brands were not available at low doses, so participants would start off on a daily dose of one drug but might have to switch to a different medication once they reached higher doses. The switching caused adverse reactions for many participants, and some were serious enough that the participants stopped taking the drugs, Brady said.

Participants also struggled to get prior authorizations from their doctors, many of whom didn't understand the requirements.

The New Program

"One of the reasons we started making changes to the program is because of public opinion," Brady said. "These drugs were really being publicized, so I had a lot more people inquiring or trying to get on the drug that theoretically probably weren't the ones that we really wanted to treat.

"This drug is not for somebody who wants to lose 20 pounds for their daughter's wedding in three months," he added. "This drug is to really try to curb some of these people from having medical conditions later on and reduce that medical spend. We wanted to make people healthy, but we wanted to make the right people healthy."

The fund also wanted to hold participants more accountable. "This isn't a magic pill, a free pill. They have to do some work," Brady stressed.

The fund implemented the more restrictive program on July 1, 2024. Previously, a participant could qualify for coverage if they had a body mass index (BMI) of 27-30 with two comorbidities (e.g., diabetes or hypertension) or a BMI of over 30 with no comorbidities. The new required BMI is 27-32 with two comorbidities or a BMI of over 32.

"It potentially knocked out some people from being able to get that drug, but we did feel that it moved the needle to treat the people who I think we would get a long-term return on investment for," Brady said.

Michael P. Brady
Administrator,
Laborers' Local 157
Benefit Funds,
Schenectady, New York

Members who take the drug must participate in a lifestyle management program that is administered by a third-party telehealth vendor contracted by the fund's PBM. The fund pays a per member per month (PMPM) fee for the lifestyle program.

Member requirements include the following.

- Lose 5% of body weight within seven months in order to receive the next one-year prior authorization for the drug.
- Step on a monitored scale at least four times a month. The weigh-in is live, and the scale transmits the information directly to a telehealth nurse.
- Interact with the telehealth vendor's web application four times a month. Interactions could include messaging a health coach or participating in a challenge on the app.

To limit the possibility that previously qualified members would lose coverage when the new coverage requirements took effect, members were allowed to use their baseline BMI from when they first started taking the drugs. No member lost coverage as a result.

Brady cited the following participation statistics.

- 5.3% of the plan's adult population is taking a GLP-1 for weight loss, but only 2.9% are actual members.
- 50% of program participants are spouses.
- 1.1% of male members and 24% of female members are taking GLP-1s, although Brady noted that the plan has a small female population.

The PBM and the fund office worked with the existing participants to educate them on the new requirements.

GLP-1 Coverage Trends

Across the United States, demand for antiobesity medications started taking off in 2021, said Stephen Wolff, a principal and pharmacy management consultant with Milliman, Inc. Milliman worked with the Local 157 fund to analyze the costs of covering antiobesity medications. "Now that we have a lot of public discourse on it, it seems that more plans are adding coverage than are removing coverage," Wolff said. However, plans are struggling with the cost, and some are considering removing coverage.

AJ Ally, a principal and pharmacy management consultant with Milliman, said it's been difficult for employers and benefit funds to predict utilization of GLP-1 drugs once they start covering them for weight loss. Some plans have gone backward and stopped covering the drugs, "which is a very hard thing to swallow. So it's very important that you get the coverage criteria right up front," he said.

Coverage Philosophy

Brady acknowledged that the Local 157 fund has some unique attributes that played a role in the decision to cover GLP-1 drugs for weight loss.

Because they work in the construction industry, participants are mostly male, active and healthier than workers in more sedentary roles, so a lower percentage probably needed the drugs, he noted. Participants also tend to remain covered by the benefit funds longer because of their pension and apprentice programs. "If a participant started this drug today, it's likely that we're going to cover this participant under our plan for 15-20 years, maybe more," and reap the benefits of providing the coverage, Brady said. "Our thought process was they're still going to be part of our plan when they don't need a hip replacement because they weren't carrying around an extra 50 pounds. They won't have a heart attack. Potentially, they'll never get diabetes."

In addition, the fund had nearly four years of reserves to provide a cushion for cost increases. "We were to the point where our deductibles and coinsurance structure for our plans were very low. We were trying to figure out ways to give back to our participants," Brady said. "We saw this as some form of a wellness program, and that's the way we've continued to do it."

Many plan sponsors are debating how they should design coverage of the drugs, Ally and Wolff commented. Plan sponsors question whether to provide the drugs only to those participants with the highest BMIs where they may be able to see an immediate return on investment (ROI) or think more long term and aim to prevent future health issues by covering the drugs for those with lower BMIs.

"Do you take a more preventive approach like Michael is doing? That's the first school of thought," Ally explained. "The second school of thought is where do I get the best bang for my buck right now because I don't have the resources to cover everyone? So do I target my resources on the high-risk population where I can get a return very quickly?" Ally added that one resource is an obesity management framework developed by the nonprofit Digital Health New York. The framework may help employers have important discussions with their health plan, PBM and third-party vendors

about what they can do to implement, improve or manage coverage going forward.

That quandary will likely continue until the prices of the drugs come down, Ally said. "Right now, the net price is two to four times higher than the rest of the developed world. We do have to solve the cost issue."

Rebates are a major factor in determining coverage thresholds and have a big impact on plan costs.

Typically, plans that have more restrictive programs—requiring step therapy and higher BMI for coverage—may not receive rebates for GLP-1 drugs from their PBMs, Ally explained. Those plans may pay the full list price of $1,000 to $1,200 monthly for the drugs, whereas plans that have more liberal programs aligning to rebate contracts may pay a net cost of $500 to $600 after rebates.

Advice for Other Plans

Brady suggested that a plan newly implementing GLP-1 coverage might want to consider it a member-only benefit to help manage costs. Funds are also better off starting with a restrictive program and then expanding it rather than implementing a more liberal program and then contracting it, Brady said.

"One thing that's really important is to have a very well-monitored PBM contract," he added. The contract should require the PBM to conduct market checks annually to take advantage of drug price fluctuations for all drugs. "I save 6-7% a year in pricing on my market check alone, so if my increase because of GLP-1 spend is 10%, I'm bucking most of that because I have a pretty active contract."

He recommended that funds actively monitor their program, both to ensure member buy-in and to prevent fraud and abuse. Knowing your participants is also important, Brady said. Plans that have a more sedentary population may have a higher number of people taking the drug.

Brady, Wolff and Ally also offered additional advice for plans considering GLP-1 coverage.

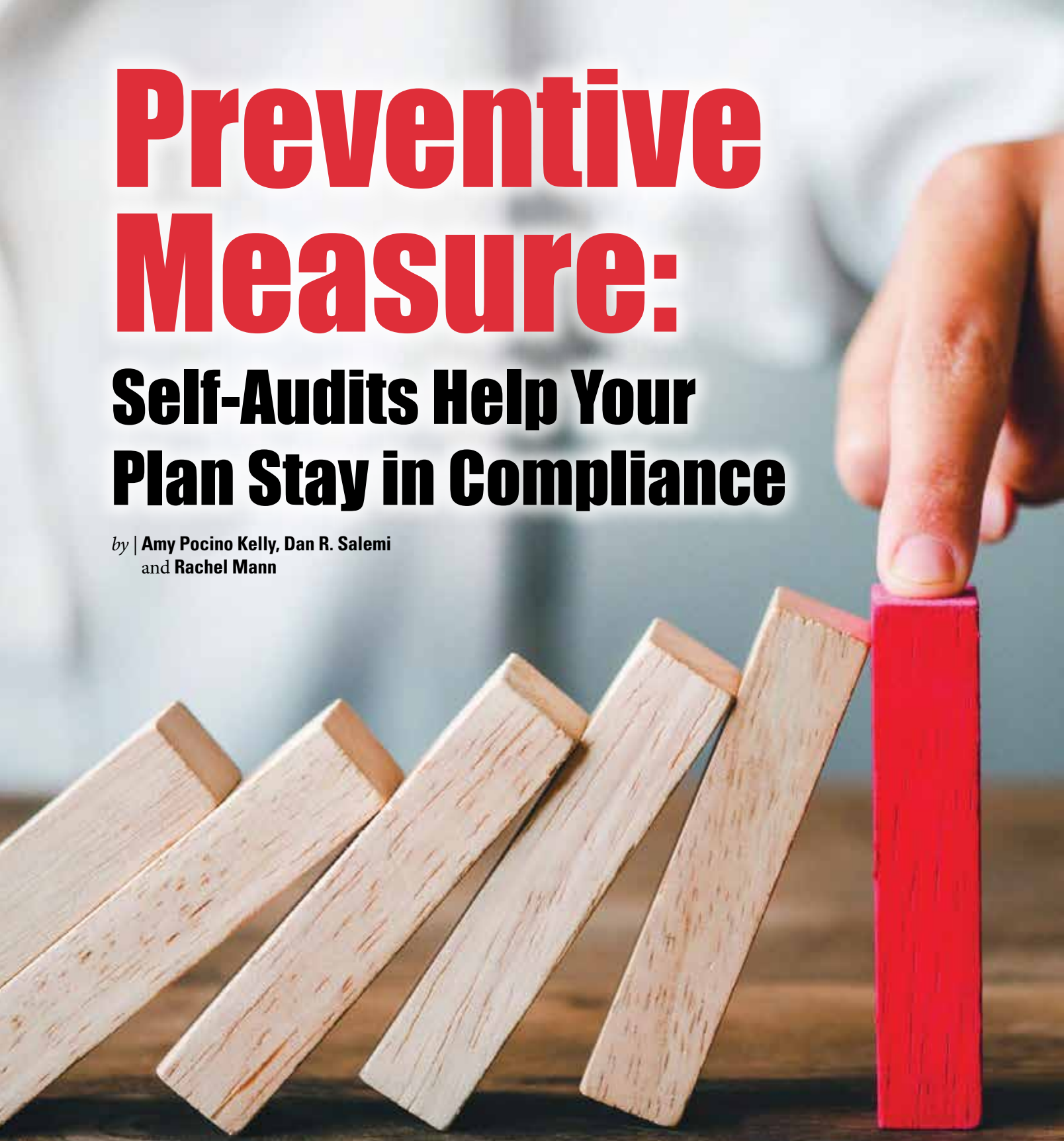
- **Clearly define program objectives.** "You have plans that are concerned with controlling cost at all costs, and you have plans that want to offer aggressive benefits to attract and retain workers. You have plans that want to keep this member for a long time and want to avoid the long-term negative outcomes," Wolff said. Plans should outline their goals for coverage and then track whether those goals are being met.
- **Understand and monitor costs.** Plans should know their budget and monitor expenses once they implement coverage.
- **Track long-term outcomes.** The Local 157 fund plans to survey participants to find out how the medications are impacting other aspects of their lives. For example, Brady wants to find out whether they have fewer mental health visits, have been able to stop taking other medications or have avoided surgeries such as a knee replacement.

Administering and communicating the new program was a "heavy lift," Brady concluded. "I'm happy to say that as of today, we have everybody online doing well and going in the right direction."

Preventive Measure:

Self-Audits Help Your Plan Stay in Compliance

by | **Amy Pocino Kelly, Dan R. Salemi** and **Rachel Mann**



Self-audits can help employee benefit plans avoid potential fines and costly corrections while also ensuring that they are paying benefits in accordance with their governing documents. These audits may be more attractive to plans following the passage of SECURE 2.0, which contains provisions that incentivize retirement plans to identify and correct errors.

Due to a significant increase in government agency investigations of plans in recent years, a growing number of employee benefit plan sponsors and boards of trustees are interested in conducting internal compliance self-audits, primarily to ensure that any governmental agency audits of their plans go smoothly.

Although many plans are required to obtain an annual financial statement audit opinion, the financial statement audit process in many cases will not include the fulsome operational review that would be needed to ensure that the plan is consistently operating in compliance with applicable law or the plan's own governing documents.

A preemptive self-audit can help plans identify and correct compliance or operational errors before they are discovered by an agency, such as the U.S. Department of Labor (DOL) or Internal Revenue Service (IRS), during an agency audit. Self-audits also can ensure that plans are paying benefits in accordance with their governing documents. Plans that conduct such audits may avoid large agency fines and overpayments as well as corrections processes that may require agency input and approval.

This article will discuss the self-audit process and identify common areas of compliance that plans should target. It will also highlight changes affecting self-audits that are included in the SECURE 2.0 Act of 2022, a package of retirement plan legislation.

What Is a Self-Audit?

A *self-audit* is generally a review of the plan's operational practices against current versions of the written plan document. A self-audit like this is typically designed at the outset to focus on specific operational practices. Once the audit scope is defined, those responsible for conducting the audit will generally work with the plan's administrator to review the in-scope operational practices against the governing plan document provisions and applicable law. They will work to either confirm that such practices are consistent with the plan's terms and applicable law or identify compliance gaps that should be reviewed and potentially corrected. It is a good practice to consider conducting a focused self-audit whenever an operational error is discovered in the routine course of plan administration. In addition, plans should consider a broader self-audit every few years, particularly after there has been a change in a key plan administrator vendor, such as a new third-party administrator (TPA).

Self-audits can help plans and their fiduciaries avoid costly corrections and allegations of breach of fiduciary duties. Sections 402(a)(1) and 404(a)(1)(d) of the Employee Retirement Income Security Act (ERISA) require every employee benefit plan to be established and maintained pursuant to a written instrument and administered according to its written terms. Establishing the plan is a nonfiduciary settlor activity, but the plan's fiduciaries have a fiduciary duty under ERISA to follow the written plan document while managing and administering the plan. Failure to follow the written terms of the plan creates a potential breach of fiduciary duty.

If they don't conduct such self-audits, many boards of trustees and plan administrators may not have appropriate familiarity with the plan terms or certainty that the plan's administrative practices are consistent with the plan terms. This could result in ongoing errors and potential fiduciary breaches that could continue for days, weeks, months or even years if not addressed.

takeaways

- Self-audits can help employee benefit plans identify and correct compliance or operational errors before they are discovered by an agency, such as the Department of Labor (DOL) or Internal Revenue Service (IRS). Self-audits also can ensure that plans are paying benefits in accordance with their governing documents.
- Regular self-audits review the plan's operational practices against current versions of the written plan document. They may be conducted with assistance from a consultant, legal counsel or combination of the two.
- Self-audits may be more attractive to plans following the passage of the SECURE 2.0 Act of 2022, which contains provisions that incentivize benefit plans to act quickly to identify any previously undiscovered errors and correct them as soon as possible.
- Common areas of focus in recent retirement plan audits by the DOL and IRS include benefit calculations, procedures for finding missing participants and cybersecurity.

Who Should Conduct a Self-Audit?

Although the method of conducting a self-audit may depend on the type of plan involved, the most effective self-audits are typically conducted with assistance from a consultant, legal counsel or combination of the two. They are often in a better position to objectively evaluate whether the plan's administrative practices comply with applicable law and governing plan documents.

Outside counsel or third-party benefits consultants can also bring deep industry knowledge and broad perspectives to the self-audit and government agency audit process. These types of benefits professionals are more likely to have experience with many types of audits by different government agencies and to have intimate knowledge of the particular audit trends and priorities of the auditors. In addition, they should have experience correcting a wide range of errors and should know the appropriate prospective and retroactive correction options that are available, should errors be discovered. Outside counsel and consultants are also more likely, as compared with the plan's internal staff, to be objective and lack any inherent bias when identifying existing errors and determining whether a particular administrative practice is consistent with the plan's governing documents.

Attorney-Client Privilege

Privilege is one of the benefits of engaging legal counsel when conducting a self-audit, although it is limited as described below.

Work product that is created during a self-audit, including reports, memos, presentations and emails, is not generally protected by any sort of privilege. Merely including outside counsel on the self-audit team or including outside counsel on emails does not cause the work product to become protected from discovery through attorney-client privilege.

The discovery of any nonprivileged work product that discloses area of risk for a board of trustees and the plan(s) it oversees can be a gold mine for a government investigator or plaintiff's attorney and a land mine for trustees.

When a self-audit is directed by counsel and is done in anticipation of or in preparation for a governmental investigation or litigation, the attorney-client privilege will typically attach to that work product. The ability to protect self-audit work product from damaging discovery is a significant incentive to perform a self-audit at the direction of legal counsel who are engaged to help prepare for a potential or hypothetical government audit or litigation.

SECURE 2.0 Expands the Use of the IRS Self-Correction Program

Self-audits may be more attractive to retirement plans following the passage of SECURE 2.0, which contains provisions that incentivize retirement plans to act quickly to identify any previously undiscovered errors and correct them as quickly as possible.

SECURE 2.0 significantly expands the ability of retirement plan sponsors to "self-correct" certain failures that may arise in day-to-day plan operation and administration. The IRS maintains the Employee Plans Compliance Resolution System, which includes a Self-Correction Program (SCP) through which retirement plan sponsors can self-correct certain types of errors without making a submission to the IRS or obtaining IRS approval. Before SECURE 2.0 was passed, the SCP was available only for limited operational and plan document errors.

SECURE 2.0 expands the scope of operational and plan document errors that can be self-corrected and allows retirement plans to self-correct any "eligible inadvertent failure" to comply with applicable requirements of the Internal Revenue Code (the Code). An *eligible inadvertent failure* is defined as any failure that occurs despite the existence of practices and procedures that are reasonably designed to promote and facilitate compliance with applicable requirements of the Code. However, eligible inadvertent failures do not include any failure that is egregious, relates to the diversion or misuse of plan assets, or is related (directly or indirectly) to an abusive tax-avoidance transaction.

The opportunity to self-correct eligible inadvertent failures is available unless (1) the IRS identifies the failure before any self-correction actions are initiated or implemented, or (2) the self-correction was not corrected within a "reasonable" period after the failure was identified. There is no hard deadline to correct eligible inadvertent failures, provided that the failure is corrected before it is identified by the IRS and within a reasonable period after it is discovered. The IRS has stated that a "reasonable period" is determined by considering all relevant facts and circumstances, and that, in most cases, a correction within 18 months of identification of the error would be considered reasonable.

These two SCP limitations demonstrate the importance of identifying errors early. If an error is identified within a "reasonable" period—and prior to an IRS audit—it may be corrected through SCP without IRS approval. Early identification and prompt correction can save plans and their fiduciaries significant time and money by allowing them

Four Sample Issues/Areas for Self-Audit for Retirement Plan Sponsors

These four questions represent common areas of focus in recent retirement plan audits by the Department of Labor (DOL) and Internal Revenue Service (IRS).

1. Is the plan staff or the plan's third-party administrator calculating benefit (e.g., pension) payments and offering the appropriate distribution options and pension commencement date to participants in accordance with the terms of the plan?
2. Primarily in the case of a defined contribution plan, what is the plan's definition of "compensation" and do the contributing employers follow that definition when making contributions?
3. Does the plan have a sufficiently prudent process for identifying and locating missing participants?
4. Does the plan have sufficiently prudent cybersecurity protections to protect plan assets from cybertheft?

to bypass official corrections programs that require agency oversight. See page 58 for additional information about self-correction procedures available through the DOL's Voluntary Fiduciary Correction Program.

SECURE 2.0 Institutes New Deadlines for Overpayments

Other provisions of SECURE 2.0 provide relief and establish new rules regarding the correction of overpayments from retirement plans, further demonstrating the importance of identifying and correcting pension/retirement benefit payment errors as soon as possible.

Retirement plan overpayments generally include payments that a participant receives that exceed what is permitted under plan terms or applicable regulatory limits. Overpayments may include amounts that a participant is not entitled to receive under the terms of the plan (e.g., incorrectly calculated pension benefits) or amounts that a participant receives prematurely (e.g., impermissible in-service distribution of amounts from a 401(k) plan).

SECURE 2.0 provides that a retirement plan fiduciary will not be considered to have breached its ERISA fiduciary duties if the fiduciary exercises discretion to not seek recovery of an overpayment. If, however, a plan fiduciary does decide to recoup overpayments, SECURE 2.0 establishes rules and limits on how this recoupment effort can be undertaken.

One new overpayment rule from SECURE 2.0 provides that a fiduciary may not seek to recover past overpayments from a participant or beneficiary if the first overpayment occurred more than three years before the participant or beneficiary was first notified of the error in writing. Similar to the new SCP rules, this overpayment rule incentivizes fiduciaries to self-audit plans regularly since the faster a plan identifies overpayments, the more likely it will be able to recoup those overpayments. If the plan fails to identify the overpayment and notify the participant/beneficiary in time and therefore misses the three-year deadline, the plan will no longer be able to recoup the overpayment.

Government Audit Trends and Priorities

Below is a list of some common areas of focus in recent retirement plan audits by the DOL and IRS.

- Is the plan staff or the plan's TPA calculating benefit (e.g., pension) payments and offering the appropriate distribution options and pension commencement date to participants in accordance with the terms of the plan? This is an area of plan document compliance that is often overlooked, in many cases because the plan's benefit calculation and commencement/application processes are not regularly reviewed for compliance with both the current plan document and applicable law.
- Primarily in the case of a defined contribution plan, what is the plan's definition of "compensation" and do the contributing employers follow that definition when making contributions? Possible corrections include:
  - –Amending the plan's definition of compensation to align with the contribution practices of contributing employers or ensuring that contributing employers are making deferral and/or employer contributions in accordance with the plan's current definition of compensation
  - –Determining whether contributions should be refunded for amounts that were improperly included or retroactively amend the plan to match the definition of compensation to the plan's operation in practice. Note that retroactive amendment via an SCP may be available, depending on the circumstances (as discussed above).
- Does the plan's summary plan description (SPD) accurately identify the plan's administrator and fiduciary/fiduciaries? Possible corrections include:
  - –Amending and redistributing an updated SPD to include required information
  - –Investigating whether any specific operational errors were caused by a lack of communication between the participants and plan administrator/fiduciary/fiduciaries, including errors related to the claims and appeals or beneficiary designation processes.

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- Does the plan have a sufficiently prudent process for identifying and locating missing participants? Possible corrections include:
  - –Maintaining (and regularly updating) accurate census information for all plan participants, both current and retired/terminated
  - –Coordinating with the recordkeeper to quickly flag missing participants through returned or uncashed checks, bounced emails, etc.
  - –Checking related plan or other company records for additional methods of communication for the participant or next of kin, as well as communicating with beneficiaries or other participant contacts for updated contact information.
- Does the plan have sufficiently prudent cybersecurity protections to protect plan assets from cybertheft? Possible corrections include:
  - –Coordinating with the plan's recordkeeper and other third-party service providers to ensure that they are complying with the DOL's cybersecurity guidance
  - –Reviewing contracts with third-party providers or engaging in a request for information with existing providers to ensure cybersecurity contractual provisions and operations are robust
  - –Updating participant communications and/or conducting participant training to inform participants on cybersecurity steps they can take to ensure safekeeping of their assets, such as safe storage of passwords and regular monitoring of online accounts.

Conclusion

The prospect of a random or targeted government investigation of pension, retirement, and health and welfare plans is daunting. The best way to prepare for a potential investigation is to conduct regular self-audits to help ensure that the plan's operation is consistent with its governing documents and applicable laws. Plans and their boards of trustees should therefore strongly consider conducting regular self-audits to ensure that any governmental investigation of the plan goes smoothly.

bios

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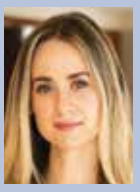

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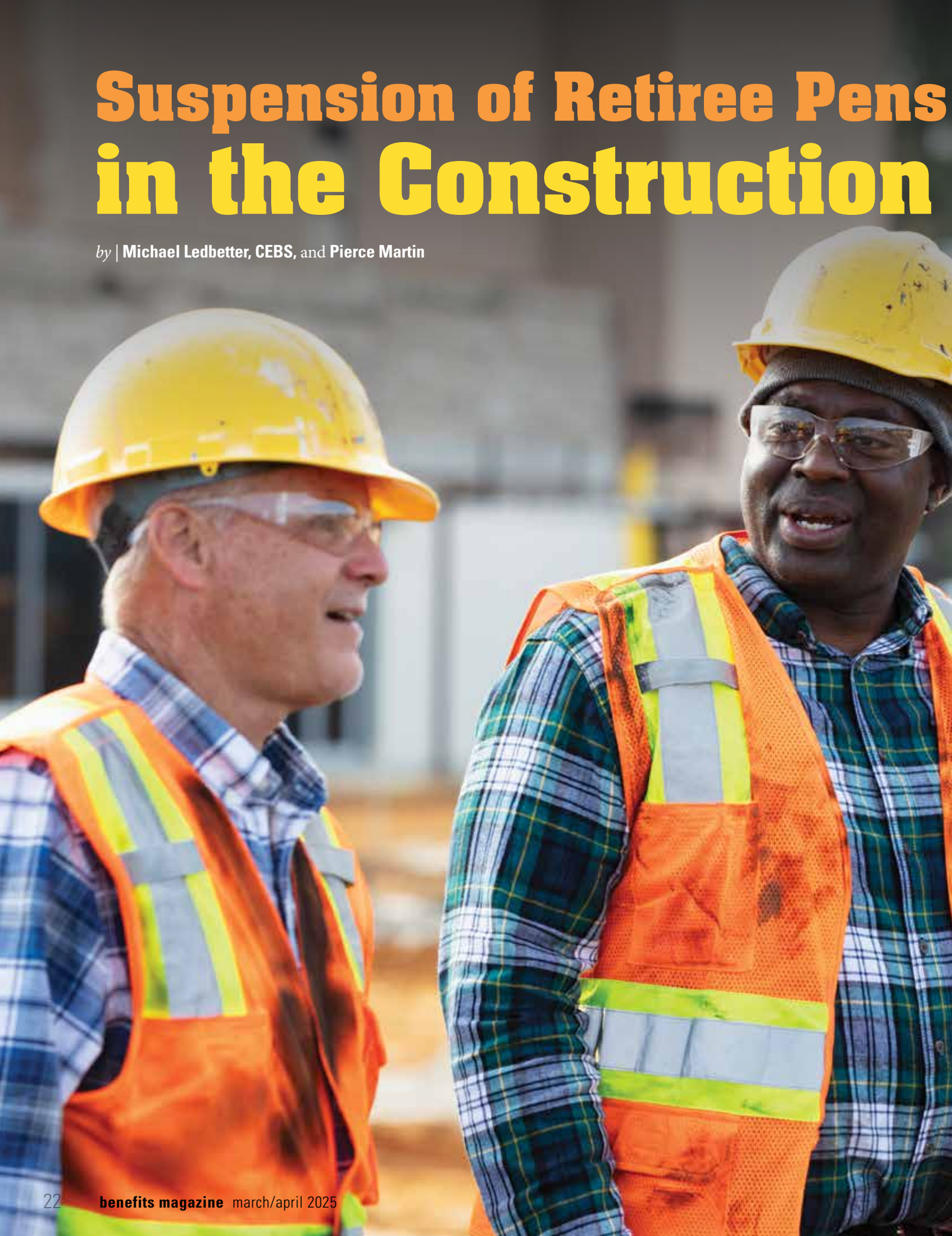
Suspension of Retiree Pens in the Construction

by | **Michael Ledbetter, CEBS,** and **Pierce Martin**



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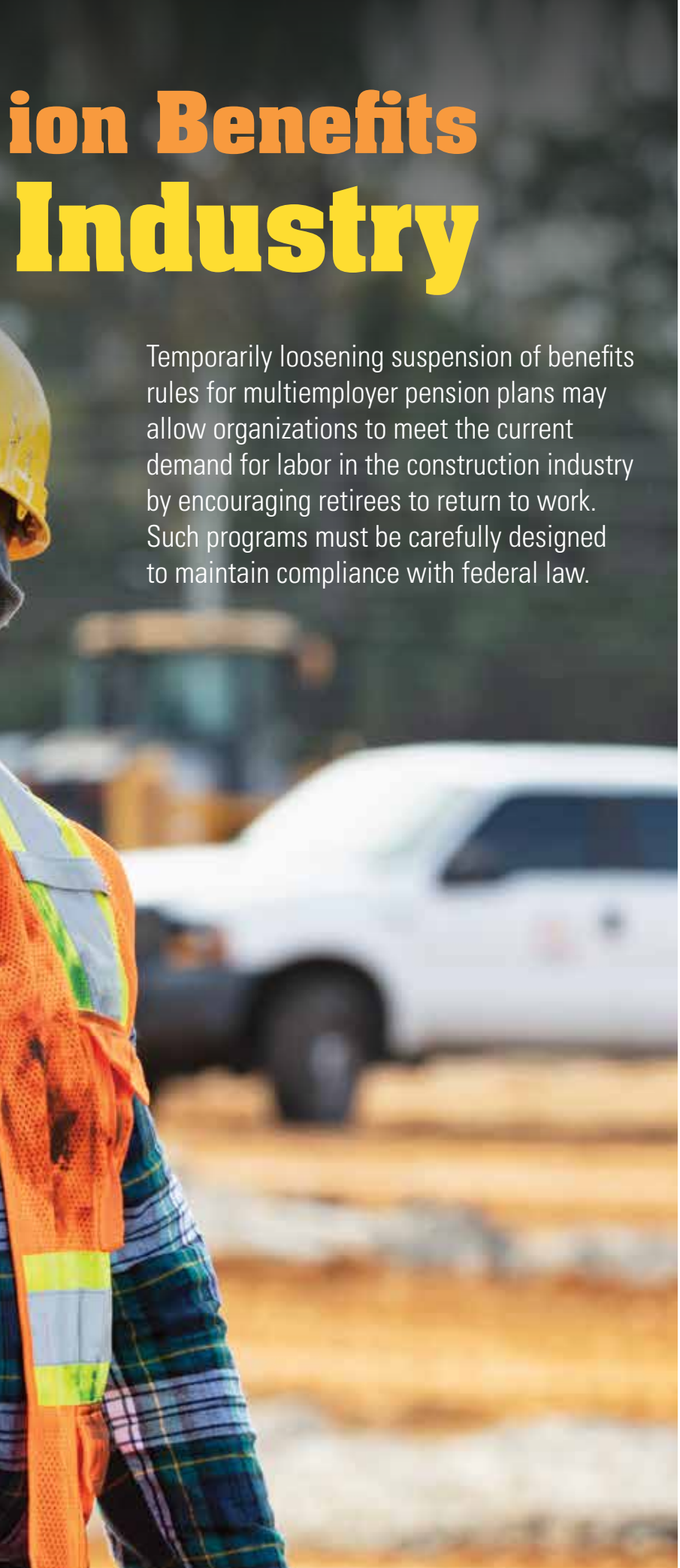

Temporarily loosening suspension of benefits rules for multiemployer pension plans may allow organizations to meet the current demand for labor in the construction industry by encouraging retirees to return to work. Such programs must be carefully designed to maintain compliance with federal law.

Federal law allows retirement plans the option to suspend the pension benefits of any participant who has retired but returns to work in disqualifying "Section 203(a)(3)(B) Service."[1] This rule has traditionally been used by plans to prevent retirees from "double dipping" and to preserve employment opportunities for the active workforce. However, because of the unprecedented demand for skilled construction workers, many trustees are rethinking their approach to suspension of benefits. Instead of penalizing those who return to work, unions, employer groups and pension plan trustees are promoting temporary changes to entice retirees to fill open positions.

The United States is experiencing a heavy construction boom, with megaprojects underway in several parts of the country. At the same time, unions, employers and project owners are dealing with an aging and shrinking construction workforce. It is estimated that on top of normal hiring rates, the industry needed to recruit an additional half-million construction workers in 2024 to keep up with demand.[2] While apprenticeship classes are growing, it takes time for newly indentured apprentices to become productive journeyworkers.

To help bridge the gap and fill open positions, many groups are encouraging retirees to return to active service. While retirees always have the option to suspend monthly retirement payments and return to work, very few are interested in doing so. By temporarily loosening suspension of benefits rules, groups can provide a strong incentive to retirees by allowing them to continue to draw retirement benefits while simultaneously earning the same wage and benefit package as other collectively bargained employees.

When carefully planned, this type of program can be a tremendous benefit to the retiree, the retirement plan and the industry. This article explores the suspension of benefits rules and discusses issues to be considered if the suspension rules are modified.

Caution: Plans Cannot Allow Sham Retirements and Must Comply With the Separation of Employment Requirements

Before considering any changes to suspension rules, trustees need to understand that the Internal Revenue Service (IRS) requires participants to experience a bona fide separation of employment before they begin receiving retirement benefits. Unless a plan allows in-service distributions,[3] trustees may not allow participants to retire and immediately return to work under lenient suspension rules. For example, in a private letter ruling,[4] the IRS explained:

> *" . . . employees who 'retire' on one day in order to qualify for a benefit under the Plan, with the explicit understanding between the employee and employer that they are not separating from service with the employer, are not legitimately retired. Accordingly, because these employees would not actually separate from service and cease performing services for the employer when they 'retire,' these 'retirements' would not constitute a legitimate basis to allow participants to qualify for early retirement benefits (which are then immediately suspended). Such 'retirements' will violate section 401(a) of the Code and result in disqualification of the Plan under section 401(a) of the Code."*

To comply with the separation requirements, it is important that trustees apply a suspension of benefits moratorium and extension thereof only to those who have been separated from employment with all contributing employers and retired for a reasonable period. For example, a plan that intends to lift the suspension of benefits rules for one year beginning on March 1, 2025 may require a person to have retired by October 1, 2024 to qualify. Many plans also require retirees to sign a form at retirement acknowledging the separation requirements and attesting that they have no plans to return to covered service. Regardless of the approach taken, the plan must ensure that participants have experienced a bona fide separation from employment and are legitimately retired before returning to work.

Overview of ERISA Suspension of Benefits Rules

ERISA Section 203 contains the minimum vesting standards that apply to defined benefit (DB) and defined contribution (DC) retirement plans.[5] In addition to mandating vesting schedules, this section states that a participant's benefits must be nonforfeitable at normal retirement age—In other words, they cannot lose these benefits. Despite this requirement, Section 203-3(a) allows a retirement plan to suspend early retirement benefits for any type of reemployment. Section 203(a)(3)(B) and the accompanying regulations[6] also allow a normal retirement benefit to be suspended when a retiree returns to work for 40 or more hours of service[7] in a month:

- By an employer that maintains the plan under which such benefits were being paid in the case of a single employer plan
- By a multiemployer plan if the plan is in the same industry, in the same trade or craft, and the same geographic area covered by the plan as when such benefits commenced.

While boards have the right to permanently remove the suspension of benefits provisions from their plans, trustees understand that the construction industry is cyclical. When work opportunities are scarce, it is not in the best interests of the industry or stakeholders to allow retirees to continue to work in covered employment and take jobs that would otherwise be held by union members who are not yet eligible for retirement. For that reason, any modifications to make suspension rules more lenient are usually temporary and will last only as long as there is a heavy demand for labor.

Caution: Suspension of Benefits and Anticutback Rules

Both ERISA and the Internal Revenue Code prohibit any plan amendments that reduce or eliminate a participant's accrued benefits, early retirement benefits, retirement type subsidies and other forms of optional benefits offered by retirement plans. Trustees who are considering changes to their suspension rules should be aware of two important issues relating to the anticutback rules.

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1. ***Central Laborers' Pension Fund v. Heinz* (2004) decision:** This U.S. Supreme Court decision prohibits a plan from implementing more restrictive suspension rules to benefits that have already been accrued. For example, if a plan contained no restrictions on postretirement work, the trustees could implement new suspension provisions but would need to do so on a prospective basis only. Any benefits earned by participants through the date of the change could not be affected. When properly adopted, a temporary suspension of benefits moratorium will not be impacted by the *Heinz* restrictions.
2. **Temporary benefit changes and accrued benefit rule:** Applicable IRS regulations[8] provide that a pattern of repeated temporary plan amendments may eventually be considered a permanent part of the plan—and thus protected from cutbacks. There is relatively little guidance on this regulation, but in a 1992 revenue ruling,[9] the IRS explained that plans should ensure that (1) the amendment must be made on account of a specific business condition, (2) the amendment must relate to that specific business condition and (3) the business condition must be temporary, as opposed to permanent. Trustees who intend to temporarily modify the postretirement work restrictions should consult with counsel and ensure that the minutes and communications with participants/retirees squarely address and document each of these three elements. In addition, if work demands are seasonal or cyclical, it may be wise to allow the suspension moratorium to expire during months of lower employment.

Overview of Rules and Impact of a Suspension Moratorium on Participants Not in Pay Status by Normal Retirement Date

Participants who are not yet in pay status at the time of their normal retirement date are subject to specific rules governing their benefit depending on their working status, age and plan rules as well as whether a suspension of benefits moratorium has been implemented.

Participants Not Working in Disqualifying Employment

Employment that disqualifies a participant from benefits generally occurs when they work 40 or more hours per month outside of the collective bargaining agreement, but still within the same industry, trade or craft and within the plan's jurisdiction. For instance, if a participant worked 15 years as a union electrician and then accepted an electrical project manager position in the same geographical area, that new role would be considered disqualifying employment. However, if that same participant worked in an unrelated industry, that employment likely would not be disqualifying. Participants who are not engaged in disqualifying employment are entitled to an actuarial increase to their retirement benefits if they postpone their retirement beyond their normal retirement date. This increase compensates for the delayed start of payments, maintaining the overall value of their retirement benefits regardless of their retirement date. In simpler terms, this means the participant will receive a higher monthly benefit payment, but they will likely draw that benefit for a

takeaways

- Under federal law, pension plans can suspend the pension benefits of any participant who has retired but returns to work in certain types of jobs. Traditionally, plans have used this rule to prevent retirees from double dipping.
- To help address labor shortages in the construction industry, some plans are encouraging retirees to return to work and are loosening suspension of benefits rules or implementing moratoriums on these rules. This allows retirees to continue to draw their retirement benefits while earning the same wage and benefit package as other employees.
- The Internal Revenue Service (IRS) requires participants to experience a bona fide separation of employment before they begin receiving retirement benefits. Unless a plan allows in-service distributions, trustees may not allow participants to retire and immediately return to work under lenient suspension rules.
- Trustees should make sure that any suspension of benefits moratoriums changes do not violate anticutback rules. They also should be aware of how a suspension moratorium affects participants at normal retirement age who are not in pay status.
- Plans that implement a suspension moratorium need to have a procedure in place for the calculation of potential additional accruals of benefits for retirees who return to covered employment.
- Trustees should communicate the changes to the suspension rules to affiliated health plans in advance. Health plan trustees will need to determine how benefits will be impacted when retirees decide to return to work.

shorter period. A suspension of benefits moratorium will not change this requirement.

For example, assume Joe is not working in disqualifying employment and has an annual accrued benefit of $20,000 but chooses to delay his retirement for two years past his plan's normal retirement date of 65. Regardless of whether his plan has adopted a suspension moratorium, he will be entitled to an actuarial increase on his accrued benefit. This increase is typically based on an actuarial calculation utilizing the interest rate and mortality assumption used by the plan but can sometimes be a simple formula based on the number of months of the delay. Depending on the method used by his plan, it would be reasonable to expect Joe's accrued benefit to increase to $25,000 at age 67.

Participants Working in Covered Employment

Participants who engage in work that requires contributions paid on their behalf into the fund are working in what is defined as *covered employment*. The impact of continued covered employment on a participant's retirement benefit will vary depending on whether they receive an annual suspension notice[10] starting at their normal retirement date and whether the plan has implemented a suspension moratorium.

If the plan has not temporarily modified its suspension rules and the participant receives an annual suspension notice upon reaching their normal retirement date and continues to work 40 or more hours per month, they likely will not receive an actuarial increase for the period of continued employment. Instead, their benefit will continue to grow according to the plan's standard accrual formula.[11] In other words, they will earn the same annual benefit as any other participant, but they won't receive an extra increase to compensate for their delayed retirement.

If the participant does not receive an annual suspension notice or the plan temporarily modifies its suspension rules, the situation becomes more complex. Depending on the specific plan design, the participant might be eligible for either the actuarial increase, the standard benefit with additional accruals or both.

Working Retirees: Suspension of Benefits Moratorium and Its Impact on Additional Benefit Accruals

Plans that implement a suspension moratorium need to have a procedure in place for the calculation of potential additional accruals of retirees who return to covered employment and determine whether the retiree's monthly benefit will increase because of such employment. This presents unique challenges and varying complexities to plan administrators. Depending on the plan language, retirees may accrue additional benefits in addition to their regular monthly payments. Alternatively, the retiree may be awarded only the greater of the monthly benefit payments or the new accrued benefit. These scenarios are further described below.

Monthly Benefit and Additional Accrued Benefits (No "Offset" Applied)

Some plans allow retirees to continue receiving their monthly retirement benefit while simultaneously earning standard wages and accruing additional benefits based on their new service. Typically, at the start of the next plan year, the monthly benefit would be increased to reflect the additional accrual. This approach provides a strong incentive for retirees to return to work but requires careful actuarial consideration to maintain plan funding levels. The plan actuary will need to determine the financial impact of offering such a generous benefit. If the portion of the contribution rate that goes toward funding accruals is low in comparison with the portion allocated to the general funding of the plan, this could still result in a financial benefit to the plan.

Greater of Accrued Benefit or Value of Benefits Paid ("Offset" Applied)

Alternatively, some plans stipulate that retirees are entitled to the greater of the additional accrual earned during the reemployment period (calculated as an actuarial present value for their remaining lifetime) or their retirement benefits received during the period of reemployment. This offset calculation is typically measured on a plan year basis, but some plans use different measurement periods.

For a simple example of one methodology, assume that the working retiree is receiving an annual benefit of $50,000, the additional annual accrual for the postretirement employment was $2,000 and the actuarial present value factor for an annual benefit at the current age is 10.0. The present value of the additional accrual is equal to the annual accrual multiplied by the actuarial present value factor, so $2,000 x 10.0 = $20,000. Since the value of the benefits received ($50,000) is greater than the present value of the additional accrual ($20,000), the result would be no increase to the participant's current benefit.

The offset method is the most financially advantageous to the plan since it typically does not lead to an increase in retiree benefits. However, it is still very generous to the working retiree since they are receiving both their retirement benefit as well as the wages from covered employment. For plans that are underfunded and experiencing worker shortages, employing working retirees and using the offset method can generate a surplus by allowing the plan to retain additional contributions that would otherwise be used to fund accrued benefits.

Impact on Health and Welfare Plans and Contributions for Working Retirees

The interaction between working retirees and health and welfare funds is another critical consideration. If the pension plan has a sister health fund, trustees should be aware of the eligibility requirements and seek input from the health plan before a suspension moratorium is adopted. Early retirees often have subsidized self-pay rates, and a plan can have different options to credit incoming contributions for the working retirees. It is important that the health plan trustees are given time to understand the moratorium, consider their options to deal with incoming contributions and communicate that decision to the retiree population.

In addition, special consideration should be given to Medicare-eligible participants to comply with the Medicare Secondary Payer rules or to properly transition the participant between the active plan and the Medicare Advantage plan, if applicable.[12] With proper coordination on how the pension and health plans' rules are structured, a working retiree can be a financial benefit to both the pension and health funds.

Temporary Plan Change to Allow Retirees to Return to Work—Example

A union in the Midwest has a megaproject underway in the jurisdiction that will last for years. In addition, several other large commercial projects will place a severe strain on the ability of the union to supply trained workers. Despite having a significant number of travelers in the jurisdiction, several open job calls remain unfilled, and the problem is only expected to get worse over time. Apprenticeship classes have been expanded, and organizing/recruiting efforts are in motion, but a significant skilled labor shortage persists. To help combat this problem, the plan trustees adopted a temporary suspension of benefits moratorium. Under this program, a retiree may return to covered employment and work unlimited hours while continuing to draw a monthly retirement check. This is a significant financial benefit to the retirees and provides some assistance to the union, employers and industry.

Before adopting the suspension moratorium, the trustees consulted with the bargaining parties to determine the work outlook in the jurisdiction over the next few years. They also considered the work outlook for other neighboring unions to determine whether the labor shortage could be managed with travelers (workers from union locals outside of the project's geographic area). Ultimately, it was determined that even with travelers, newly organized members and additional apprentices, the bargaining parties would still have difficulty meeting industry demand. The trustees then worked with the plan actuary to determine the cost impact and learned that the additional contributions from working retirees would benefit the plan.

After deciding to implement a suspension of benefits moratorium, the board made the option available only to those who had been retired for at least six months. The trustees also communicated the reasons for the temporary change and noted that it would be closely monitored. The initial moratorium was set to expire after six months but has been extended several times. The program works well for the retirees, the plan and the bargaining parties. The suspension moratorium cannot solve the labor shortage, but it helps the union and employers entice retirees to fill a portion of the open job calls.

Communication and Additional Considerations

Communication with retirees about a suspension moratorium can be challenging. When implementing a moratorium on the suspension of benefits for retirees returning to covered employment, it is important to include direct language specifying the eligible class of retirees, the length of the moratorium, the type of work permitted, benefit accrual rules, impact on health plan eligibility, etc. Plan trustees should work closely with fund counsel to be sure that the moratorium language is narrowly tailored to address the labor

shortage in the jurisdiction and does not have a negative financial impact on the plan. If the plan will use the offset method described above, clear communication is especially important. Actuarial calculations are already a complex concept to explain to participants, and the offset needs to be clearly understood before the retirees return to work.

Finally, trustees should give due consideration to the administrative complexity that the moratorium will create. For example, is the administrator comfortable calculating the actuarial offset, or does the fund need to engage the actuary to determine these calculations? Does the plan document properly provide how the postretirement benefits are determined, or should additional amendments be adopted? The trustees, administrator and plan professionals need to be on the same page regarding the plan's intentions.

Conclusion

When considering relaxing the suspension of benefits rules, trustees should be cognizant of the ripple effects that such a change will have on the benefit plans, active participants and the bargaining parties. These decisions can have long-lasting ramifications, affecting immediate labor needs, opportunities for retirees, plan funding and the next generation of union members. Extending the availability for retirees to "double dip" when work slows could result in a loss of development among younger members, leading to future worker shortages and causing a cycle of contraction that could ultimately harm the plan and industry. Therefore, trustees must navigate any changes with caution, utilizing their fund professionals to map out the impact of these changes while maintaining compliance with federal law. When implemented effectively, these changes can serve as a valuable tool to bolster workforce participation, enhance plan sustainability and support industry needs.

Endnotes

1. Employee Retirement Income Security Act (ERISA)203(a)(3)(B); Internal Revenue Code (IRC) 411(a)(3)(B); 29 CFR 2530.203-3(a). The rules for suspending the benefits of early retirees are much more lenient, and plans could potentially prohibit any type of postretirement work. As a practical matter, most plans only prohibit early retirees from working in the same industry, trade and craft as active plan participants.
2. "Construction industry will need more than half a million workers in 2024." National Roofing Contractors Association.
3. Under the SECURE Act, plans may offer in-service distributions as early as age 59½ but must be amended to do so.
4. Private Letter Ruling 201104738.
5. Historically, the suspension rules have not been a concern to defined contribution (DC) plans because a participant could take a full distribution from the plan before returning to work. However, as more DC plans allow periodic distribution options, plan fiduciaries need to consider the impact of the suspension rules.
6. 29 CFR 2530.203-3 "Suspension of pension benefits upon reemployment."
7. Special rules apply to plans that do not calculate the actual hours or service and to those who work in the maritime industry. See 29 CFR 2530.203-3(c).
8. 1.411(d)-(4)(c).
9. IRS Rev. Rul. 92-66.
10. 29 CFR 2530.203-3(b)(4). Plan fiduciaries should discuss the annual notification requirements with legal counsel to ensure compliance with the suspension regulations. Absent proper communication, plan participants may be entitled to actuarial increases that were not intended.
11. IRC 411(a)(3)(b); ERISA 203(a)(3)(B); 2530.203-3.
12. For more in-depth information on the impact working retirees have on a health fund, see "Returning Retirees: Considerations for Health Plan Fiduciaries," by Paul Catenacci, *Benefits Magazine,* May/June 2024.

bios

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heard on community | dependent verification and documenting midyear life events

Marriages, deaths, births and other major life events don't wait for open enrollment, so what's the best way to verify the need for benefit changes when these happenings fall outside of the typical benefits calendar? That was the topic of a recent discussion on Foundation Community.

the question

I'm looking for information on how other employers handle documentation for benefit changes related to midyear life events and/or documentation to verify dependents for benefits eligibility. Here are some questions:

- Do you require documentation to verify life events (e.g., divorce decree, proof of loss of coverage, etc.)?
- Do you require documentation to verify dependent status (e.g., birth certificate, marriage certificate)?
- If you verify dependents, how frequently do you re-verify? Do you complete dependent audits?

the conversation

We hired an outside company in 2015 to conduct a dependent audit. After that was completed, we require documentation for all enrollments (new hires, life events). We have not asked for any re-verification. Documents required for dependent and life events are:

- Children: birth certificate
- Stepchildren: birth certificate and marriage license
- Spouse: marriage license (we do not cover domestic partners)
- Midyear life events: documentation showing when the prior coverage ended.

We will not approve any enrollments until the documents are received.

We do not verify dependent status at this time but are considering verifying that the spouse is not offered health insurance coverage elsewhere as a stipulation to be covered under our plan for the 2026 plan year.

We have about 19,000 benefits-eligible employees. We do require documentation for midyear life events. Our HRIS system allows attachments to be collected during the online life event processing, but we also accept documentation via email or fax or mail. We did an entire audit a few years back and we will likely need to do another full audit again in the next couple of years

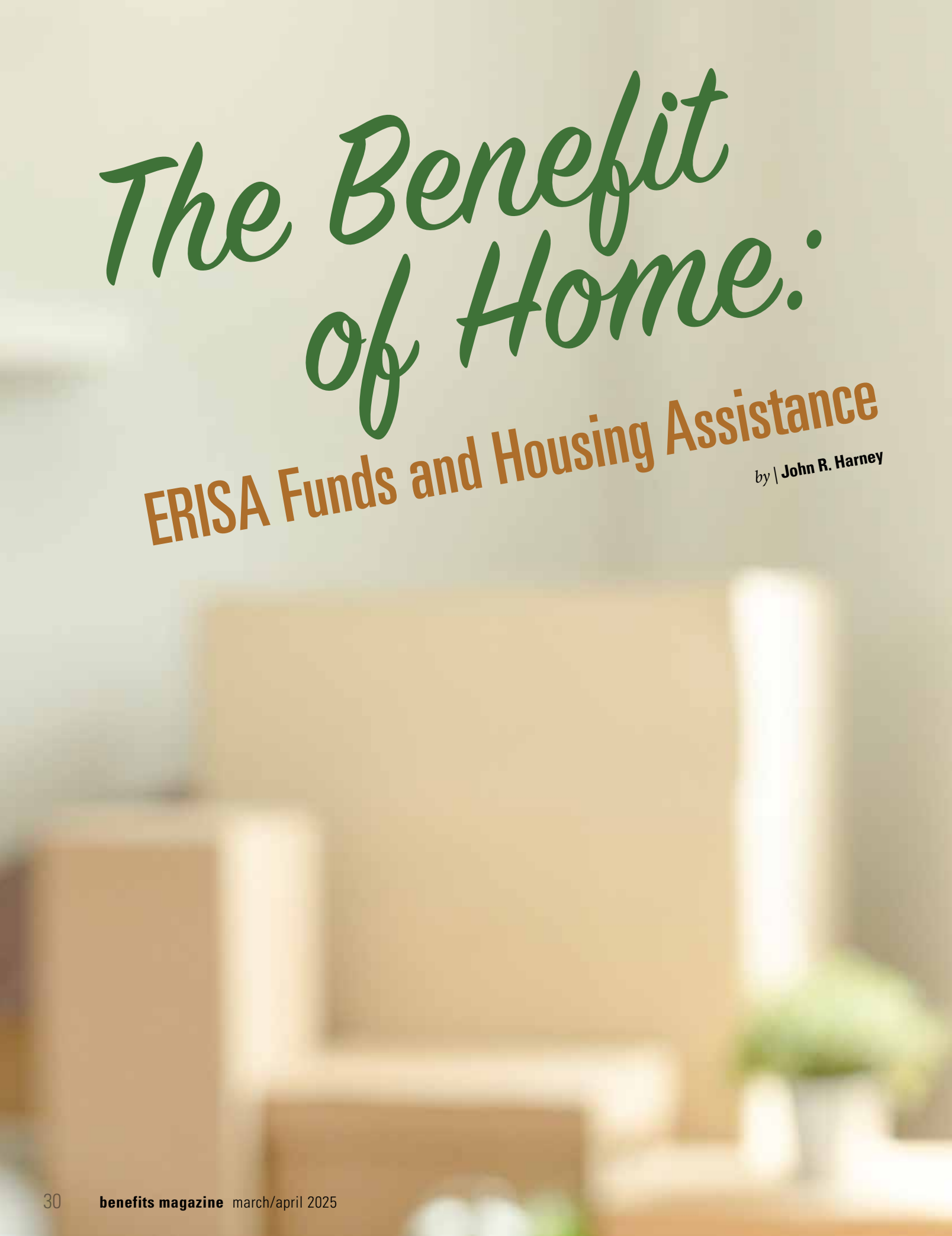
We have just under 5,000 employees and do require documentation to verify life events and dependent eligibility. We do not have a cadence set to re-verify at this time, but it is common to perform a dependent audit every two to three years.

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

The Benefit of Home:

ERISA Funds and Housing Assistance

by | **John R. Harney**



Finding affordable housing is a challenge for many workers across the country. What role can ERISA funds play in helping workers obtain housing?

A shortage of affordable housing presents a major challenge to workers, employers and communities nationwide. Housing costs are a problem for most U.S. workers ages 25-40 and, coupled with child-care demands, put a sizable dent in working family budgets, pricing many out of the real estate market.

Affordable Housing Challenges

A 2023 study from the National Association of Realtors (NAR) showed that, nationwide, middle- and low-income buyers with annual incomes below $75,000 (the median household income in the United States) are effectively priced out of the housing market since only 23% of real estate listings were affordable for those households.[1] NAR research showed that 96% of the 100 largest metro areas in the country had shortages of homes that families earning under $75,000 a year could afford to buy. However, the problem of affordable housing is not limited to large cities. In Boise, Idaho for instance—a city with fewer than 236,000 people—just 2% of the homes were affordable for households earning $75,000.[2] The shortage of available affordable housing stock in both major cities and places like Spokane, Washington; El Paso and McAllen, Texas; and Fresno and Riverside, California effectively keeps many low- and middle-income families from obtaining adequate housing.

Research[3] shows that improving access to affordable housing in the U.S. is the most cost-effective strategy for reducing childhood poverty and increasing economic mobility. Stanford economist Raj Chetty found that children who moved from high-poverty to lower poverty neighborhoods saw their earnings as adults increase by approximately 31%. They also experienced an increased likelihood of living in better neighborhoods as adults and a lowered likelihood of becoming a single parent. Moreover, children living in stable, affordable homes are more likely to thrive in school and have greater opportunities to learn inside and outside the classroom.

This article will explore how ERISA welfare funds can help their participants through the provision of an employee housing assistance benefit and address the structural challenges that ERISA plans have in providing housing assistance. It will also discuss the potential for ERISA funds to invest in housing for low- and moderate-income workers.

Housing Benefits in Action

In the case of UNITE-HERE Local 26 in Boston, Massachusetts, housing assistance became a benefit for members with two or more years of enrollment in the health benefit fund. They are eligible for a no-interest loan of up to $10,000 to be used for the down payment or closing costs of a participant's primary residence located within 55 miles of the member's workplace. The interest-free loan is secured by a lien on the primary residence recorded at the appropriate registry of deeds. The loan is repayable in full upon the earliest of the member's sale of the property at an amount equal to or greater than the original purchase price, relocation or death.

Similarly, since 2007, the Culinary and Bartenders Housing Partnership provides housing assistance to members of Culinary Workers Local 226 and Bartenders Union Local 165.*

UNITE-HERE Local 26 has helped over 1,100 members and their families find their first home while the Culinary and Bartenders Housing Partnership in Las Vegas has assisted more than 1,700 members and their families achieve home ownership.

*Greater Boston Hospitality Employers Local 26 Housing Program Member Agreement and Culinary Workers Union Local 226 (Las Vegas, Nevada) website.

Housing Assistance and ERISA Funds

While some employers in the technology industry may consider a return to the company town with the creation of employer-designed communities,[4] the creation of a housing assistance program that can help low- and moderate-income workers and their families achieve housing security through an ERISA welfare plan can be the start of addressing the housing needs of workers and their communities.

Using Qualified Retirement Plan Assets for Housing

Under ERISA, plan loans to participants are considered prohibited transactions where the recipient is a party in interest or a disqualified person. In a 1981 opinion letter,[5] the Department of Labor (DOL) weighed how ERISA

applied to investment programs under which "multiemployer plans may offer mortgage loans to plan participants and beneficiaries." Framed as an investment program for a pension fund rather than a plan benefit, the DOL noted that the plan fiduciaries would need to consider the factors provided in the regulations under ERISA §404(a)(1)(B), such as portfolio diversification, the liquidity needs of the plan, the projected return of the portfolio relative to the funding objectives of the plan, and the opportunity for gain and risk of loss associated with the investment.[6]

If plan participants received a lower interest rate on the proposed mortgage loans, the DOL found that such an investment would not be prudent within the meaning of ERISA's fiduciary duty when compared with other investments. Noting that the statutory class exemption found at ERISA §408(b)(1) for loans to parties in interest requires a "reasonable rate of interest," the DOL opined that the reasonable rate of interest would be the rate established under a similar "arm's length" loan. Because ERISA fiduciaries could not consider the "incidental advantages" that a lower than market interest rate for plan participants would provide in evaluating an investment strategy, the DOL held that a mortgage loan program adopted to provide mortgage financing for plan participants would be unlawful if it did not meet the requirements of the DOL's regulations on the investment duties of plan fiduciaries.

Given this position, ERISA pension plans are effectively prohibited from providing below-market-rate mortgages to their participants. Consequently, hardship withdrawals from 401(k) plans may be the only means whereby an individual plan participant may use the assets of a qualified retirement plan to help finance the purchase of a primary residence.[7] Participants may take a distribution from a retirement plan for immediate and heavy financial need for, among other reasons, "[c]osts directly related to the purchase of a principal residence for the employee (excluding mortgage payments)."[8] However, those distributions come with costs in the form of automatic 20% withholding and a 10% penalty for early withdrawal along with the inclusion of the hardship withdrawal in the participant's gross income for that tax year. While 401(k) plan participants may take a hardship distribution to finance the purchase of a principal residence,[9] they do so at the risk of undermining their retirement security.

Housing Assistance Funds

While the use of ERISA pension plan assets for housing purposes became problematic, there remained another alternative.

In 1990, Congress amended Section 302 of the Labor Management Relations Act of 1947 (LMRA) by adding Section (c)(7) to include "financial assistance for employee housing."[10] In doing so, Congress added housing assistance to the types of benefits that could be included in an employee welfare benefit plan.[11] However, very few welfare plans have taken advantage of this legislation to provide this form of benefit. This change came about following lobbying efforts by a Massachusetts hotel workers union (currently UNITE-HERE Local 26) in the 1980s.

In Boston in the 1980s, 78% of unionized hotel workers could not afford to buy an apartment in metropolitan Boston and 98% could not afford to buy a house, despite the fact that a majority of these workers held down more than one job.[12] In 1988, Boston hotel workers and their employers negotiated a housing assistance benefit, and the union conducted an 18-month campaign to amend LMRA Section 302(c) 29 USC §186(c) to permit the bargaining parties to create the housing fund.[13] Prior to the 1990 amendment, welfare plans were limited to the benefits enumerated in LMRA Section 302(c) that addressed health, retirement, apprenticeship and training. With the amend-

takeaways

- Finding affordable housing is a challenge for many people in the United States. Research shows that only 23% of real estate listings were affordable for households with annual incomes below the median household annual income of $75,000.
- Hardship withdrawals from 401(k) plans may be the only way for individual plan participants to use the assets of qualified retirement plans to buy a primary residence since Employee Retirement Income Security Act (ERISA) pension plans are effectively prohibited from providing below-market rate mortgages to their participants.
- ERISA plans may offer housing assistance to their members through a housing trust. The benefit was made available through the passage of an amendment to the Labor Management Relations Act (LMRA) in 1990.
- A housing assistance benefit could come in the form of a no-interest loan for the downpayment or closing costs for a primary residence.

ment, ERISA welfare funds were able to include housing assistance with the benefits that could be provided by an ERISA welfare plan.

As explained by Representative Bill Clay of Missouri, the principal sponsor in the House, the amendment made the creation of a housing trust a permissive subject of bargaining under the framework established for benefit funds under the Taft-Hartley Act. Allowable assistance by a housing assistance plan would include "payments to employees for down payments, closing costs, bank fees, mortgage interest buydowns, and initial rental costs such as security deposits and first month's rent."[14] Clay also indicated that the housing assistance trusts contemplated by the amendment would be employee welfare benefit plans subject to ERISA and its general fiduciary and prohibited transaction provisions. Passed with bipartisan support, the amendment was signed by President George H.W. Bush on April 18, 1990.[15]

With the passage of the amendment, ERISA welfare plans were able to offer housing assistance benefits in conformance with the provisions of the new Section 302(c)(7). Many ERISA welfare plans are exempt from income taxation under Internal Revenue Code Section 501(c)(9) as voluntary employees' beneficiary associations (VEBAs). VEBAs can provide life benefits, sick and accident benefits, and other benefits intended to safeguard or improve the health of a member and their dependent or protect against a contingency that interrupts or impairs a member's earning power, including any benefit provided in a manner permitted by paragraphs 5 et seq. of Section 302(c) of LMRA.[16]

Many would argue that housing assistance improves the health of the members and their families since homelessness affects both physical and mental health.[17]

This type of housing assistance benefit provided through an ERISA welfare fund has the potential to give low- and moderate-income workers and their families the opportunity to become first-time homeowners and purchase a primary residence that will allow them and their families to accumulate home equity and a chance to acquire wealth that can be passed onto future generations. The concept of providing participants with an interest-free loan for the purchase of a primary residence is a relatively simple concept that offers a potentially life-changing benefit for workers and their families.

Moreover, the benefit places a small administrative burden on the plan, making it an attractive option for plans whose participants are struggling with housing insecurity. The interest-free loan is not includible as income to the participant, and the loan becomes a receivable to the fund for audit and reporting purposes. Secured by a lien on the primary residence of the participant, the fund will have a secured interest in the residence that it retains until the loan is paid off upon sale or refinancing of the primary residence. In the event of foreclosure or bankruptcy, the fund retains its position as a secured interest.

Challenges of implementing such a benefit may include difficulty in determining how much the fund can commit to a housing assistance benefit and what criteria will be used to determine eligibility for the program.

Addressing the Housing Supply

While the availability of housing assistance through ERISA welfare funds has been shown to help workers achieve some measure of housing security, it is by no means a silver bullet to resolve the problem of housing for millions of Americans. There remains a shortage of housing for low- and moderate-income families. Zillow reports that the United States is 4.5 million homes short of demand.[18] The National Low Income Housing Coalition study shows that there is a shortage of 7.8 million rental units for extremely low-income families.[19] The manifest need for investment in housing and home construction suggests that new and creative sources of funding may be needed to address this need.

Recent DOL guidance in 2023 on using environmental, social and governance (ESG) considerations in the investment of pension plan assets suggested that plans may consider investments in affordable housing, but the results of the recent election now portend that guidance from the incoming EBSA administration may revert to the narrower standard of "pecuniary factors"[20] alone.

Given this evolving change in policy, ERISA pension plans that might consider investments in housing may need to focus on how investment in housing will meet this more narrow focus on financial return with no consideration of collateral benefits.

While noting that tax-free municipal bonds have no appeal to tax-exempt pension funds, a recent report by the Americans for Financial Reform Education Fund and Georgetown's Kalmanovitz Initiative for Labor and the Working Poor noted that bonds to

build housing that would be owned by an occupant or a nonprofit entity would not qualify for tax exemption but could be attractive as a low-risk investment in a fund's fixed income portfolio.[21] The report also suggested alternative investments in cooperative housing and housing investment trusts.

Plans that are interested in investing in housing should consult with counsel and their investment professionals to determine whether such investments meet current fiduciary standards.

Considerations for Implementing Housing Assistance Benefits

When determining whether to provide a housing assistance benefit through a welfare plan, trustees and plan professionals should consider the following.

- **Bargaining the benefit:** Are the parties to the CBA in agreement to provide a housing assistance benefit? Should the CBA require contributions to the existing welfare plan or the creation of a new housing benefit fund? Can the CBA be reopened for midterm modification?
- **Tax-exempt status:** Is the welfare plan that will provide the benefit exempt under Internal Revenue Code Section 501(c)(9) and able to provide the benefit as a VEBA?
- **Funding:** Can the fund afford to provide the benefit? Is an actuarial study needed? How is the benefit recognized in an annual audit and Form 5500?
- **Eligibility:** Who will be eligible for the benefit? Will the fund require preapproval for a mortgage loan? Will the fund require eligible participants to attend workshops on home ownership?
- **Security for loan:** Can fund counsel assist the fund in preparing and filing the proper lien documents to secure the loan?

Conclusion

ERISA welfare funds can play a vital role in helping address affordable housing shortages, whether through a housing assistance fund or plan investments in affordable housing. Funds that provide this benefit may help low- and moderate-income workers and their families purchase a primary residence that will allow them and their families to accumulate home equity and a chance to acquire wealth that can be passed on to future generations.

bio

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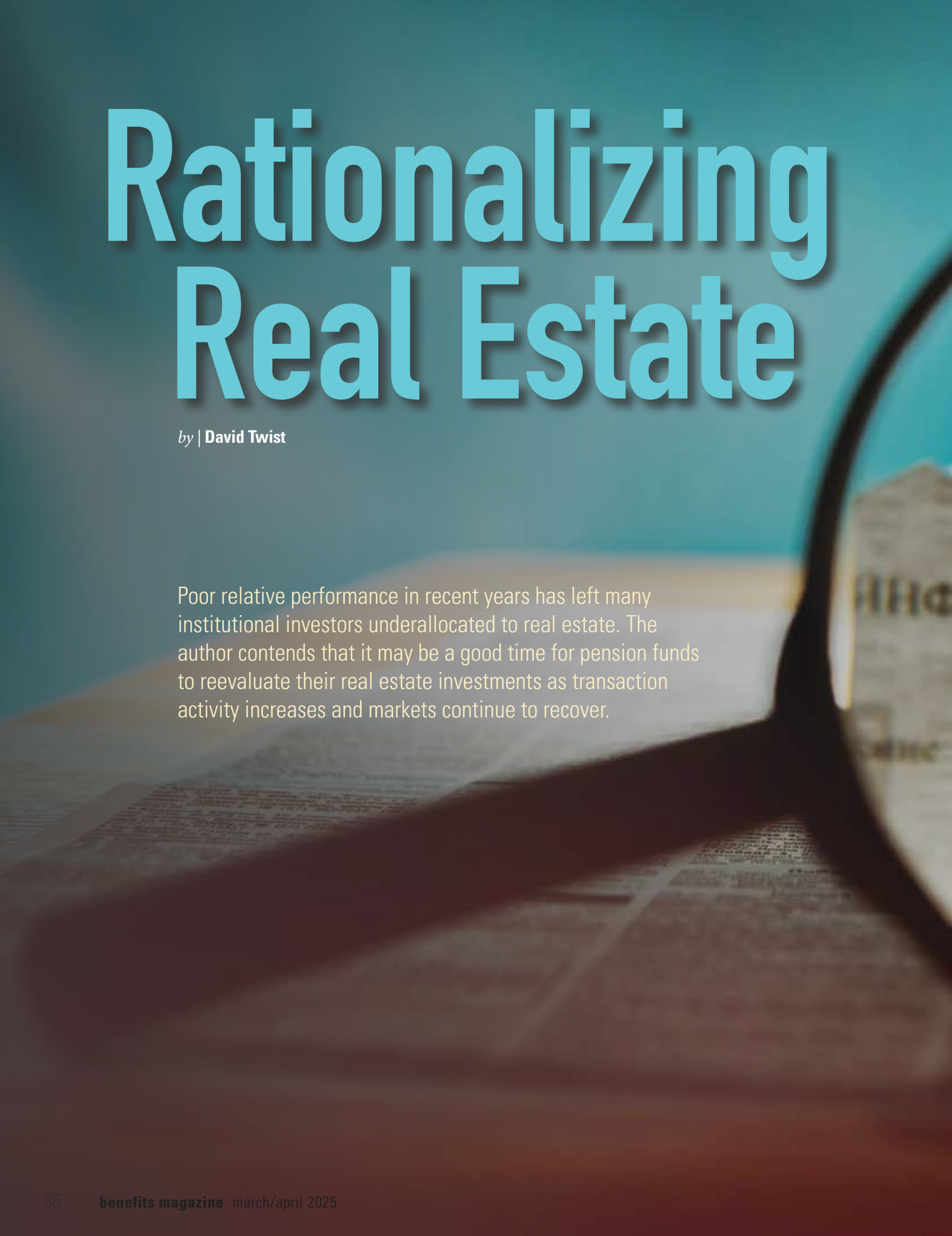
Rationalizing Real Estate

by | **David Twist**



Poor relative performance in recent years has left many institutional investors underallocated to real estate. The author contends that it may be a good time for pension funds to reevaluate their real estate investments as transaction activity increases and markets continue to recover.

Real estate is a well-understood alternative investment, and investment in real estate is commonplace among modern retirement plans. It offers both diversification and a partial inflation hedge, but falling values have frustrated investors in recent years.

As bad or worse, many open-end real estate funds (those that do not have a termination date) that tout liquidity as a key feature have been providing little or no liquidity to investors wishing to make redemptions. This is problematic when investors depend on redemptions to raise cash.

Falling interest rates and rising transaction activity have contributed to an improvement in the performance of real estate investments and their liquidity. But the sector faces competition from newer alternative asset classes such as private debt and infrastructure. These may compete with real estate for a place within the allocations that institutional portfolios make to alternative investments.[1]

Now may be an especially impactful time for pension funds to rethink, rationalize and adapt their real estate investments. This article will describe the attributes of private real estate equity investments, discuss how they are valued and offer considerations for pension funds evaluating their real estate allocations.

TABLE

Commingled Fund Types

	Core	Noncore
Subcategories	Core, core plus	Value-added, opportunistic
Risk/Return	Lower	Higher
Focus	Fully stabilized, income-producing properties	More risk, e.g. leasing, financing, renovation, redevelopment, etc.
Investment Term	Either evergreen/open-end or closed-end/drawdown-style	Almost always closed-end/drawdown-style

Real Estate Is Both Equity- and Debtlike

The fundamental appeal of investing in real estate includes the following.

- It diversifies the traditional equity/bond mix in institutional portfolios.
- It provides a partial inflation hedge.

An investment in real estate provides both current income and capital appreciation for investors, detailed below.

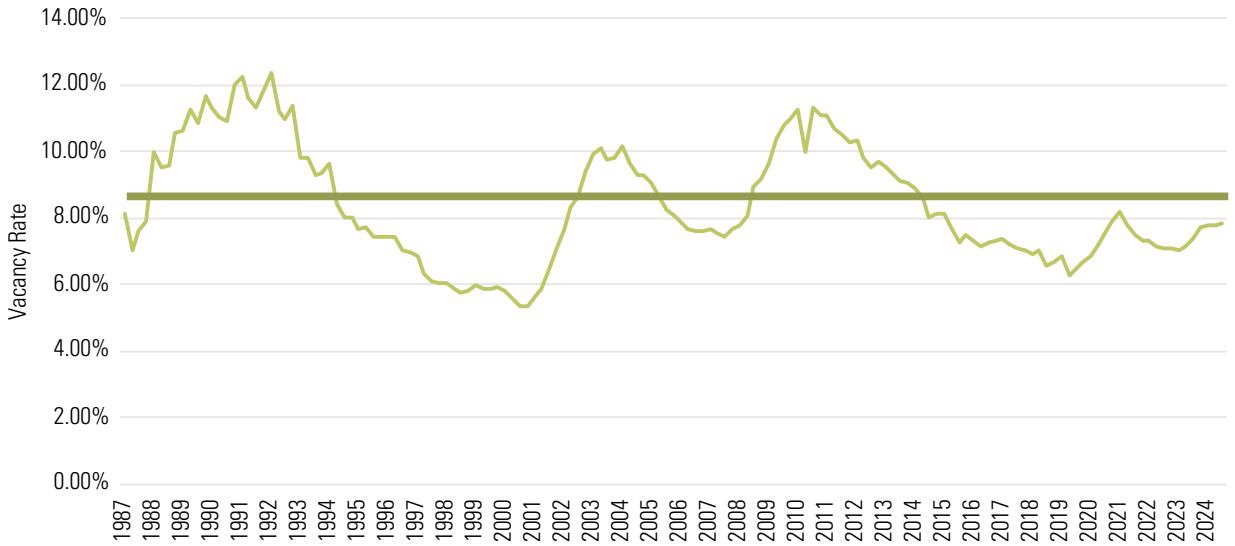
- The income component of real estate comes from the cash flow generated by contractual leases.
  - –Some sectors offer income that is short term, (e.g., multifamily residential properties).
  - –Income in other sectors (e.g., commercial and warehouse properties) is typically multiyear where leases are often with leading or growing businesses.
- Many of these leases contain *inflation escalators*, which are provisions that allow the lease terms to be adjusted with rising inflation.
- Real estate price appreciation is also (somewhat) inflation protected, since it is related to the replacement cost to assemble, build and lease the underlying property. When the prices of land, labor and/or materials go up, so should rent and the value of the property.
- Market prices depend on the factors above, as well as the cost of capital, investor sentiment and the relative attractiveness of other investment alternatives.

takeaways

- Institutional investors have been frustrated with the performance of real estate investments in recent years as values have fallen and liquidity has decreased.
- The fundamental appeal of investing in real estate is the opportunity for diversification and the partial inflation hedge it provides. Investing in real estate also provides current income and capital appreciation for investors.
- Many real estate funds are diversifying beyond traditional sectors, such as office, industrial, apartments and retail, into "alternative" real estate sectors such as medical and lab/life sciences offices, single family homes for rent, student and senior housing, data centers and self-storage.
- Real estate fundamentals remain healthy outside of the office sector. The scope of future demand for offices remains in question, and repricing of some office segments could take years to play out.
- As asset values increase and transaction activity picks up, pension funds may want to reevaluate their real estate allocation and redemption requests.

FIGURE 1

Real Estate Vacancy Rates: 1987-2024



Source: National Council of Real Estate Investment Fiduciaries (NCREIF).

Institutional Real Estate Equity Investing

Though some large institutional portfolios prefer to own (and in some cases develop) a portfolio of their own properties, building a diversified portfolio using that approach requires significant time, capital and expertise. Instead, most invest through commingled funds that have a diverse portfolio of many properties. These commingled funds can be public (real estate investment trusts (REITs)/operating companies) or private (private REITs/limited partnerships). This article will address trends in private real estate investing.

Commingled funds are usually categorized by strategy type along two buckets: "core" and "noncore," described in the table on page 38.

Many investors use the National Council of Real Estate Investment Fiduciaries (NCREIF) Index of Open End Diversified Core Equity (NFI-ODCE) Funds to evaluate the performance of core real estate investments. It consists of 25 open-ended funds[2] that are diversified by property type and geography, offer quarterly "liquidity" and have conservative limits on their use of leverage.

There are other indexes for private real estate investments, but the NFI-ODCE index is the primary index for core open-end funds, and it has been in existence since 1978.

NCREIF requires NFI-ODCE funds to have their assets externally appraised every quarter. This sets the value of the individual properties, which then combines to create the net asset value (NAV) of the fund. That is the price at which investors buy and sell "shares" of the fund.

Many institutional investors use NFI-ODCE funds because they:

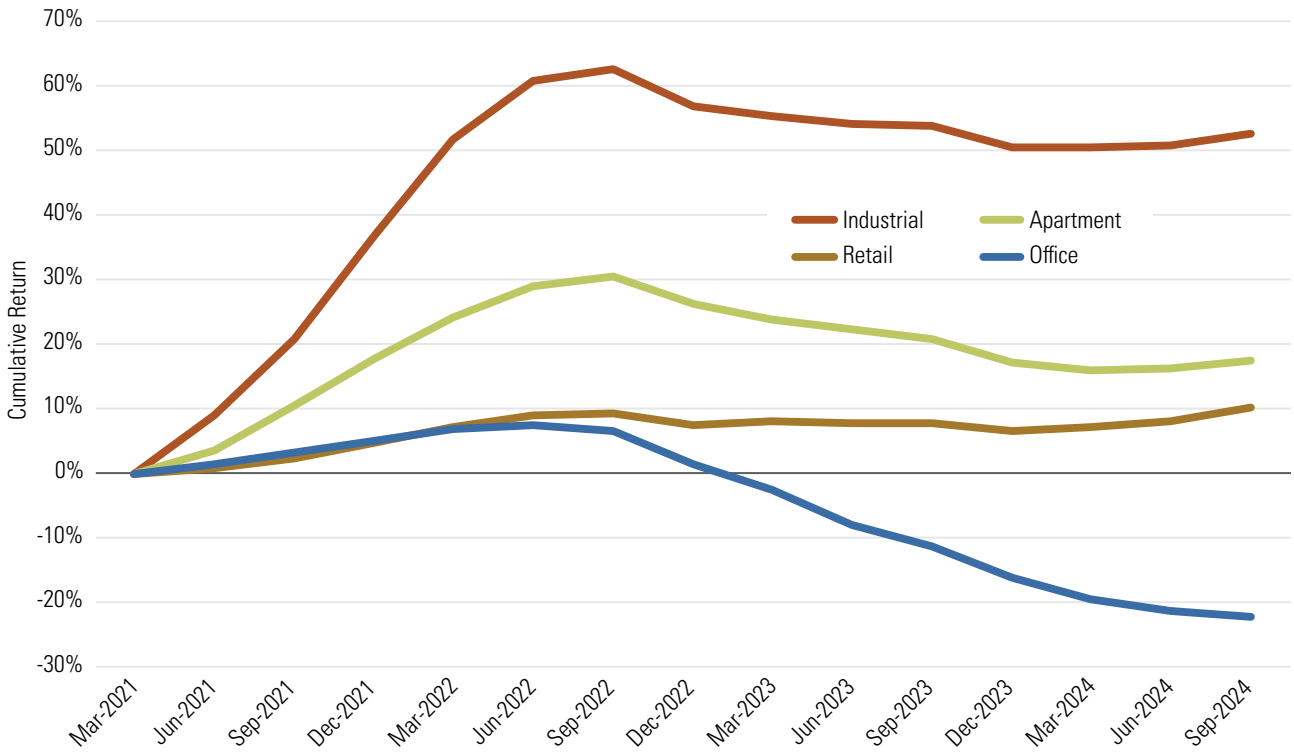
- Are relatively transparent (for purposes of appraisal)
- Have large, diversified portfolios of core assets
- Provide some liquidity mechanism.

Changing Views on Real Estate Sectors

To ensure a diversified index, NCREIF requires participating funds to invest in at least three of the four traditional property types (apartment, industrial, office and retail). Yet given the decades-long fear of the "death of retail" due to online retailers and the more recent challenges facing remote work and office buildings (office), many funds are diversifying into "alternative" real estate sectors or even infrastructure-style investments in order to move away from retail and still remain diversified.[3] These alternatives include medical and lab/life sciences offices, single-family homes for rent, student and senior housing, data centers and self-storage. The housing-

FIGURE 2

Performance by Property Type



Note: Property type data is delayed by one quarter.
Source: National Council of Real Estate Investment Fiduciaries (NCREIF).

related categories, including apartments, are often aggregated into "residential."

Questions about the future of the office sector and its potential recovery are beyond the scope of this discussion—however, it is an important one. Office is not "dead." It has always been the most cyclical of the major property types. The scope of future demand is very much in question, and the repricing of certain segments of office could take years to play out.

Figure 1 illustrates that real estate fundamentals (vacancy rates) remain healthy by historical standards, with industrial and multifamily properties realizing moderate increases. This has led to a flattening in rent growth in those property types; however, it is not declining rapidly as it did during most previous real estate downturns. The office sector remains challenged, and Figure 2 shows that while apartment, retail and industrial returns may have turned a corner, office may still be searching for a bottom.

Interpreting Real Estate's Recent Underperformance

The spike in interest rates in 2022 and 2023 caused disruption in the real estate lending and transaction markets. As rates rose, appraisers began raising the required rate of return (financing/cost of capital) of many core assets, causing their appraised values to fall. Lacking adequate transac-

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tional data, appraisers increased rates inconsistently across assets, submarkets, markets, property types and funds. The erratic timing and size of the fall in values resulted in problematic performance reporting. Investors became frustrated with unreliable values stemming from the appraisal process.

With values falling, investors attempted to redeem from many of the NFI-ODCE funds, causing many funds to partially or fully gate[4] redemptions (i.e., investors received only a portion of their requested cash-out). As a result, investors suffered through both falling values and receiving little or none of the promised liquidity.

The decline in value was likely a result of the appraisers' obscured view of capital markets at the time rather than oversupply and falling net income. The fundamentals of real estate remained attractive. It typically takes longer for the dust to settle for assets like real estate that are both illiquid and difficult to value, so investors would be well-served by focusing on their long-term targets during periods of stress.

Where Are We Today?

Transaction activity has picked up since the end of 2023, buoyed by stabilizing interest rates, increased availability of real estate credit, and narrowing of the gap between asking prices and offers from potential buyers. This increased transaction activity has helped the appraisal process. Asset values are flattening and, in some cases, beginning to increase. These changes are fueling real estate investment (and lending) and its ongoing recovery cycle.

On the investor side, the poor performance in recent years has left many investors underallocated to real estate. While many investors wait for managers to fill their sell requests (referred to as being in a "redemption queue"), they are at a crossroads where not all the redemption requests may need to remain in place. Furthermore, history shows that once values begin to rise, redemption queues often vanish.

Investors should actively evaluate their redemption requests and consider the following.

- How much real estate their portfolios should hold
- Which of the existing investments should be reduced or increased
- Their ongoing liquidity needs and tolerance for open-end versus closed-end funds
- Where they should allocate to maximize risk-adjusted return

bio

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With transactional activity rising and more consistency in the current appraisal process, some fund and asset values have begun to turn the corner, leading many to believe that a broad real estate recovery is at hand.[5]

Since real estate performed well in prior economic recoveries, institutional investors may want to consider leaning into real estate (particularly certain segments) and implementing strategic changes. For an example from history, as markets recovered from the global financial crisis, the NFI-ODCE index[6] delivered a 12.9% compound annual net return for the five years ending in 2014.

However, investing in noncore assets is still more difficult to implement than investing in core assets because the funds are primarily closed end partnerships. It is hard to predict when funds will come to market and how long they will stay open for investment. Although they typically have ten-year terms, it is difficult to predict their actual lives. Some terminate and return capital to investors sooner, and some extend and return later than initially forecast.

Since real estate is a local business, many noncore funds focus on limited geography and property types, raising concerns relating to portfolio diversification, sector exposure and risk. At any given time, there are numerous closed-end funds in the market. For example, on September 30, 2024, Preqin, an investments data company, showed active fundraising by 1,647 U.S., closed-end real estate funds. However, many of

these funds are too small or their managers are too inexperienced for many large institutional investors to consider.

Finally, since closed-end funds request capital from investors over three or four years and return it over a period ranging from as little as one year to as long as 15 years, cash flows are difficult to predict. This uncertainty in timing and liquidity requires ongoing monitoring and management of vintage diversification, liquidity and other risks.

Conclusion

Real estate tends to be cyclical. Successful real estate investors have been:

- Sensitive to and tactical to the cycles
- Thinking long term.

There has been recent discontent with the valuations, performance and illiquidity of the NFI-ODCE fund constituents; however, the index remains useful as a tool to evaluate real estate investments, and many investors still utilize core, open-end funds within their real estate portfolios.

Although institutional investment in real estate has been challenging in recent years, fundamentals remain healthy. With above-average core and noncore risk-adjusted returns potentially on the horizon, history suggests that now might be a good time for investors to reassess and rationalize their real estate portfolios.

Endnotes

1. Liquid investments are frequently and often publicly traded securities such as stocks and bonds. Historically, investors have earned a premium by investing in private investments; however, these investments might be illiquid for extended periods of time. Investors must balance their exposure to illiquid investments with their ongoing needs for liquidity.
2. As of September 30, 2024, these 25 funds had 3,337 investments totaling $282 billion in gross asset value and $207 billion in net asset value. That equates to a relatively conservative leverage ratio of 27.2%. NFI-ODCE allows no more than 35% Tier 1 leverage as defined in the NCREIF PREA Reporting Standards, which uses the fund's outstanding principal balance of debt relative to the fund's gross assets.
3. In addition to investing in at least three of the main property types, funds are required to have no more than 60% of their gross market value of real estate in one property type and have a minimum of 5% in each of the three types they are invested in. In addition, no more than 65% of real gross asset value may be in one geographic region.
4. Funds are generally not required to meet all quarterly redemption requests as they are not required to sell assets to meet liquidity requests. Gating is a mechanism that funds use to limit redemptions by investors. When a fund puts up a gate, investors may only receive a portion of their requested cashout.
5. The NFI-ODCE net return started becoming less negative in the first quarter of 2024, eventually turning to a positive net return in the third quarter of 2024, a trend that most fund managers see as continuing/strengthening in 2025.
6. One might expect noncore funds to perform even better.

member profile

Member of the Moment
Nancy Del Villar Vivé

Serving

Trustee for the International Alliance of Theatrical Stage Employees (IATSE) Local 15 Theatrical Stage Employees Health and Welfare Trust in Seattle, Washington. The fund provides benefits to 450 members in the Seattle area and state of Washington.

By Day

Director of Human Resources at Seattle Theatre Group

Biggest Challenge as a Trustee

"Being 'responsibly generous'—balancing keeping the fund sustainable while providing the best benefit for the members."

Biggest Reward

"Being able to provide a mechanism for stage workers to get health and welfare benefits. A lot of theater workers in the area do gig work, and they don't qualify for benefits at any one employer, and this provides a way for them to get those benefits."

Favorite International Foundation Educational Program

"The Annual Employee Benefits Conference. I really appreciate the trustee education that is available, and I think it's great to hear what other organizations are doing and learn more about funding, investments and best practices."

Advice for New Trustees

"Participate in learning opportunities either through the International Foundation conferences or other education programs. Get to know your fellow trustees to build that working relationship to allow you to talk about challenges and opportunities. Take it seriously and understand your function and your role as a trustee."

When I'm Not at Work

"I love gardening, and I love yoga. I'm currently training to be yoga teacher."

First Job

"In high school, I worked at a restaurant called Monterey Jack's. It was a Jack in the Box, but the Seattle area was a test market for a new name."

legal & legislative reporter

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For members of the International Foundation of Employee Benefit Plans

MORGAN, LEWIS & BOCKIUS LLP
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Named Sole Beneficiary in Legal Separation Agreement Overrides Life Insurance Plan Beneficiary

The U.S. Court of Appeals for the Ninth Circuit affirms the district court's judgment in favor of a named beneficiary of a legal separation agreement in a suit related to a claim for life insurance proceeds, finding that the legal separation agreement was a qualified domestic relations order (QDRO).

Background

The plaintiff is the girlfriend of a deceased participant of a group insurance policy who claims a right to the insurance benefit proceeds under the plan. The defendant is the group life and accident insurance company that administers the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Upon his divorce, the deceased plan participant entered into a legal separation agreement with his ex-wife, which provided that the named and sole beneficiary of the $800,000 life insurance policy was the couple's son. However, the life insurance policy listed the named beneficiary as the plaintiff. The district court determined that the legal separation agreement between the deceased plan participant and his ex-wife was a QDRO under ERISA and found that the named beneficiary under the legal separation agreement held superior rights to the named beneficiary under the plan. Therefore, the district court found that the ex-wife's son was entitled to the plan proceeds. The plaintiff appealed.

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

Decision: A legal separation agreement that names the son of a deceased plan participant as the beneficiary of a life insurance policy is a qualified domestic relations order (QDRO) and therefore overrides the designation of the participant's girlfriend as the plan beneficiary.

Arguments and Discussion

On appeal, the plaintiff argues that the legal separation agreement is not a QDRO. The plaintiff offers two theories to support her argument that the legal separation agreement is not a QDRO, both of which the court finds unsuccessful.

To qualify as a QDRO under ERISA, among other requirements, the domestic relations order (DRO) must clearly specify which plan the order applies to. Previous case law holds that substantial compliance with ERISA's specificity requirements is sufficient. Further, to be a QDRO, a DRO must not require the plan to increase the benefits it provides.

The first theory the plaintiff offers is that the legal separation agreement is not a QDRO because the document does not clearly specify the plan in the language. The court disagrees, finding that the legal separation agreement substantially complies with ERISA's specificity requirement because though the agreement only mentioned "a policy of life insurance," the participant's only life insurance policy was the plan. Because the participant held only one life insurance policy, the court found that it was clear which plan was implicated in the legal separation agreement, and substantial compliance was met.

The plaintiff's second theory is that the legal separation agreement is not a QDRO because the agreement increases the payment burden on the plan. The court also disagrees with this theory. In the legal separation agreement, no language requires the plan to provide an amount higher than the amount currently within the plan. The plaintiff argues that because the plan currently has an amount that is less than the amount stated in the legal separation agreement, the legal separation agreement will force the plan to provide the higher written amount.

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BENEFICIARY DESIGNATION

Plan Participant Ordered to Repay Overpayment of Disability Benefits

DISABILITY BENEFITS

The U.S. Court of Appeals for the Fifth Circuit affirms the district court's judgment in a suit related to repayment of disability insurance benefits, finding that the plan participant received excess disability benefits.

Background

The plaintiffs include both a husband and wife, the wife being a former participant in an insurance policy administered by the defendant plan administrator. The defendants include the insurance company that insures the disability benefits under the plan, the plan administrator and related entities.

Under the plan, if a participant becomes "totally disabled," the policy would provide a monthly income benefit of $1,500 until the participant is no longer disabled or reaches age 65. The plan defines *total disability* as the participant's inability to do the substantial and material duties of their regular job due to an injury or a sickness. Further, the plan defines a *regular job* as the occupation the participant is engaged in when a disability starts, provided that a total disability (TD) benefit is conditioned on the periodic and satisfactory proof of a continuing disability. The plan requires written proof of disability within 90 days after the end of each period a benefit was payable.

The plaintiff participant initially worked as a pharmacist at a large pharmacy chain. Her job entailed filling prescriptions, ensuring their accuracy and providing counseling to customers about their prescriptions, among other tasks. She also worked 12-hour shifts and was required to stand for extended periods. A few years after obtaining the disability coverage under the plan, the plaintiff participant was diagnosed with multiple sclerosis. As a result, she left her position as a pharmacist and applied for disability benefits under the plan.

Shortly after she began receiving her TD benefits, the plaintiff participant returned to work part-time but on a very limited basis as a pharmacy consultant. The defendants informed her that her benefits would continue because she was not working in her "regular occupation" as a pharmacist based on her part-time job description. Later, the plaintiff participant sought approval to return to work at her previous employer as a part-time on-call floating pharmacist a couple of days a week. The defendants informed her that her benefits would continue as long as she worked in a limited capacity. The defendants also expressly reserved the right to review the plaintiff participant's claim further if her working hours were to increase.

Eventually, the plaintiff participant changed jobs and took a position at another pharmacy, where her hours significantly increased from around 15-20 hours per week to 20-25 hours per week. However, despite this, she failed to update her hours or income on her annual disability status report to the defendants for over ten years, indicating only that she was "working on a limited basis." Even after the plaintiff began providing more detailed information in her annual status reports, she still admittedly underreported her hours and income. Upon further investigation, the defendants discovered that the plaintiff continued working in a reduced capacity in her regular job as a pharmacist despite her reported restrictions and limitations. As a result, the defendants discontinued all of the plaintiff participant's benefits under the plan and demanded a return of an estimated overpayment of over $222,000.

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

Decision: A disability plan participant must repay an estimated $222,000 in disability benefit payments because she could perform the substantial and material duties of her job as a pharmacist and, thus, is not qualified for total disability under the plan.

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Federal Court Affirms Decision Denying Federal Employee's Disability Retirement Benefits

The U.S. Court of Appeals for the Federal Circuit affirms the decision to deny a federal employee's application for disability retirement benefits, finding that no new material evidence was provided.

Background

The plaintiff is a former United States Postal Service (USPS) worker. The defendant is the Office of Personnel Management.

The plaintiff applied for disability retirement benefits under the Federal Employees Retirement System (FERS), claiming that she was unable to continue performing her duties as a postal carrier due to anxiety and panic attacks. The defendant denied the plaintiff's initial application for benefits, prompting the plaintiff to request reconsideration and submit additional medical evidence. The defendant reviewed the plaintiff's additional medical evidence and upheld the decision to deny the plaintiff's disability benefits.

The plaintiff then appealed to the Merit Systems Protection Board, which affirmed the defendant's decision to deny. The plaintiff filed a petition to review the board's decision and submitted additional evidence supporting her petition. Two years after a briefing on the petition for review concluded, the plaintiff submitted more evidence, which the board allowed. The board reaffirmed its initial decision and denied the plaintiff's petition for review, finding that no new or material evidence was presented to change the decision. The plaintiff now appeals the board's decision to deny her petition for review.

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

Decision: The court affirms that a former U.S. Postal Service worker who could not work due to anxiety and panic attacks is not entitled to disability benefits, finding that the additional evidence she submitted in her appeal of the initial denial lacked material or new information and, therefore, did not require further review.

Arguments and Discussion

On appeal, the plaintiff argues that the board erred (1) in its disability determination, (2) by failing to provide her a hearing, (3) by finding that her neck and back conditions were not part of her disability claim, and (4) by not considering her additional evidence. The court reviews the appeal on a limited basis, affirming the decision unless it finds the decision (1) to be arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; (2) obtained without procedures required by law, rule or regulation having been followed; or (3) unsupported by substantial evidence. Specifically, for review of a disability determination, the court is prohibited from examining factual findings or conclusions regarding disability but may assess whether there was a substantial procedural departure or an error in the administrative determination.

The court first addresses the plaintiff's allegation that the board erred by failing to grant her a hearing. The plaintiff claims that she requested a hearing, but was "scared out" of having the hearing because she did not have a lawyer. During a status conference held by the board between the plaintiff and the defendant, the plaintiff elected to have a hearing, and the hearing process was described to the plaintiff. At another status conference, the hearing process was described to the plaintiff again, and on record, she elected to withdraw her hearing request. Based on these facts, the court finds no error in the decision to provide the plaintiff with a hearing because the plaintiff decided not to have a hearing.

Next, the court considers the plaintiff's claim that the board erred in excluding her neck and back conditions from her disability claim. The

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BENEFIT DENIAL

Suit for Failure to Provide Employee Benefits Dismissed Due to Statute of Limitations

STATUTE OF LIMITATIONS

The U.S. District Court for the Eastern District of Louisiana grants the defendant's motion to dismiss an independent contractor's claim related to failure to provide employee benefits because the statute of limitations had run.

Background

The plaintiff is a former independent contractor of an audio-visual company. The defendant is the company.

The plaintiff was employed as an independent contractor in 1997 and worked for the defendant for over 24 years before he was furloughed in February 2021 after the defendant closed down due to the COVID-19 pandemic. The defendant reopened the business in September 2021 but did not permit the plaintiff to return to work. The plaintiff was officially terminated in February 2022, and at the time the plaintiff was terminated, the defendant began to hire younger employees with fewer qualifications.

The plaintiff now brings this claim, asserting that the defendant discriminated against him in violation of the Age Discrimination in Employment Act of 1967 (ADEA), the Americans with Disabilities Amendments Act of 2009 (ADAA), the Fair Labor Standards Act (FLSA) and the Employee Retirement Income Security Act of 1974 (ERISA). The plaintiff contends that the defendant violated his rights by willfully misclassifying him as an independent contractor and refusing to provide him with basic employee benefits or overtime pay for over 20 years of his direct employment.

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

Decision: An independent contractor who was not rehired by an audio-visual company after being furloughed during the COVID-19 pandemic was aware that he would not receive employee benefits when he was first hired by the company more than 20 years ago and, therefore, his FLSA and ERISA claims are time-barred.

Arguments and Discussion

The defendant moves to dismiss the plaintiff's FLSA and ERISA claims as untimely and barred by the applicable statute of limitations. The court first considers the plaintiff's FLSA claim and agrees with the defendant's argument that the claim is time-barred. The statute of limitations under FLSA begins on the date of the violation and extends for two years or three years if the violation is determined to be willful. The plaintiff's FLSA claim began to accrue in February 2021 when he was furloughed and stopped working for and receiving wages from the defendant. The plaintiff did not file his complaint until July 2024, over three years later, long after the statute of limitations passed. Further, the court reasons that even if the defendant's misclassification was willful, the complaint is still four months outside of the statute of limitations, and the FLSA claim is time-barred.

The court next considers the plaintiff's ERISA claim and finds that this claim, like the FLSA claim, is time-barred. When assessing ERISA actions, courts use the state statute of limitations, which is most like the claim at issue. In Louisiana, the Fifth Circuit has held that ERISA claims are governed by the state's ten-year period for a breach of contract claim. In an ERISA action, the cause of action accrues when the request for benefits is first denied. In this case, the court recognizes that for an independent contractor, the date of accrual may be the date the independent contractor was first hired and learned they would not be eligible to participate in their employer's benefit plan.

The plaintiff has been an independent contractor for the defendant for over 24 years and, therefore, would have learned that he would not

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Suit for Failure to Provide Employee Benefits

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receive benefits when he first began employment in 1997. The ten-year period for the plaintiff's ERISA claim would have expired well before he filed his complaint in July 2024. Consequently, the court also dismissed the plaintiff's ERISA claim as time-barred because he was aware he would not be provided benefits when he began employment as an independent contractor, and the time to file a claim for benefits has now passed.

Accordingly, the court grants the defendant's motion to dismiss the plaintiff's FLSA and ERISA claims because the statute of limitations has passed.

Reese v. Royal Audio/Video Supply Co. Inc., No. 2:24-cv-01809-SSV-JVM (E.D.La., November 12, 2024).

Participant Ordered to Repay

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The plaintiffs filed suit and motioned for summary judgment, arguing that under the plan, the plaintiff participant remained qualified for TD benefits and, therefore, was not overpaid. The defendants argued that the material facts demonstrated that the plan participant was not entitled to TD benefits and that the district court was required to grant them summary judgment. Upon review, the district court granted summary judgment in favor of the defendants. The plaintiffs appealed, arguing that the district court improperly granted summary judgment.

Arguments and Discussion

The plaintiffs contend that summary judgment was improperly granted because the district court (1) incorrectly applied Louisiana law to the plan, (2) failed to provide sufficient notice that their claims were subject to dismissal on summary judgment, and (3) failed to give them a full and fair opportunity to conduct discovery.

This court first addresses whether the district court correctly applied Louisiana law to the plan and finds that because the case is a diversity case, state substantive law was correctly applied. In Louisiana, the choice of law rules require that Louisiana law be applied to insurance policy contracts and, therefore, must be applied to the interpretation of the plan. The plaintiffs further argue that the district court erred by failing to consider whether she could perform the substantial and material duties of her regular occupation as a pharmacist in the usual and customary way. The court disagrees, finding that it is undisputed from the material facts that the plaintiff participant was able to perform the substantial and material duties of her job as a pharmacist and, thus, is not qualified for total disability under the plan.

Accordingly, because the plan participant could do the substantial and material duties of her regular job, the court affirmed the district court's motion for partial summary judgment in favor of the defendants.

Raymond v. Unum, No. 23-30498 (Fifth Cir., October 25, 2024).

Unjust Enrichment Case Allowed Against Former Plan Participant

BENEFIT LITIGATION

The U.S. District Court for the Western District of Pennsylvania denies the defendant plan participant's motion to dismiss claims for unjust enrichment after determining that the plaintiff plan administrator has set forth a plausible claim for equitable relief in its third-party suit.

Background

The plaintiff in the original suit is the ex-spouse of a former participant who was covered by an employer-sponsored retirement savings plan. The defendant is the plan administrator of the employer-sponsored retirement savings plan. The plan administrator also filed a third-party lawsuit against the former plan participant, making him the third-party defendant (defendant participant). The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

In the state court divorce proceedings between the plaintiff and the defendant participant, the participant was ordered, under the terms of a marriage settlement agreement, to pay a lump sum of $121,000 from his retirement proceeds to the plaintiff. Immediately thereafter, a domestic relations order was sent to the defendant plan administrator, which then had two years to evaluate the order and determine whether it was a qualified domestic relations order (QDRO). Two months after the evaluation period began, the defendant participant wrongfully withdrew the entire amount allocated to him under the plan before any distribution could be made to the plaintiff. The plaintiff alleged that the withdrawal breached the defendant plan administrator's fiduciary duty.

Subsequently, the state court ordered the defendant participant to pay the retirement proceeds awarded to the plaintiff, which he had previously wrongfully withdrawn. The plaintiff contends in her complaint that the defendant plan administrator violated ERISA when it allowed for the unauthorized distribution of the retirement account funds to her ex-spouse, the defendant participant, and that doing so was a breach of fiduciary duty.

In response to the plaintiff's suit, the defendant plan administrator filed a third-party complaint against the defendant participant, alleging a claim of unjust enrichment. The defendant plan administrator, as a third-party plaintiff, argues that if it is held liable for breach of fiduciary duty, the participant would be unjustly enriched if he was not required to make the plan administrator whole by repaying any wrongfully removed amounts from the plan. In response, the defendant participant filed this motion to dismiss.

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

Decision: A plan administrator has made a plausible claim in its third-party suit against a former retirement plan participant who wrongfully withdrew $121,000 from his retirement proceeds, and the claim may proceed.

Arguments and Discussion

The defendant participant argues that the claim against him for unjust enrichment should be dismissed because it is not based on ERISA but is instead based on a violation of the state court and, thus, belongs in a state court. Further, he contends that the defendant plan administrator owes an independent duty to the plaintiff ex-spouse for which he is not liable. Lastly, he argues that, in any case, the plan administrator is not liable to the plaintiff ex-spouse because the domestic relations order was not qualified.

In its review, the court finds that at this stage in the proceedings, it must determine only whether the complaint alleges facts that raise a reasonable expectation that discovery will reveal evidence to

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Unjust Enrichment Case Allowed

continued from previous page

prove the necessary elements of the claim. The defendant participant cites a number of cases that discuss the determination of whether a claim for unjust enrichment is ultimately recoverable. Still, the court finds that those cases are in the context of motions for summary judgment after the record has been developed rather than, as here, at the motion to dismiss stage.

Accordingly, the court finds that the plan administrator, as the third-party plaintiff, has set forth a plausible claim for equitable relief and denies the defendant plan participant's motion to dismiss the third-party suit.

Murphy v. HUB Parking Technology U.S. et al., No. 2:24-cv-00784-AJS (W.D.Pa., October 22, 2024).

Named Sole Beneficiary Overrides

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The court emphasizes that though the plan proceeds are less than the policy that the participant was obligated to maintain according to the legal separation agreement, the agreement was between the participant and the named beneficiary, not between the named beneficiary and the plan. Therefore, nothing requires the agreement to provide the named beneficiary with an amount higher than is already in the plan. Additionally, the named beneficiary is not requesting more than is currently in the plan. Thus, the legal separation agreement does not require the plan to provide increased benefits.

Accordingly, because the legal separation agreement qualifies as a QDRO, the court affirms the district court's grant of summary judgment in favor of the defendant.

Hartford Life & Accident Ins. Co. v. Valois, No. 23-3286 (Ninth Cir., November 5, 2024).

Claim Fails to Demonstrate That Default Into Managed Accounts Was Unreasonable

FIDUCIARY DUTIES

The U.S. District Court for the Eastern District of Virginia dismisses the plaintiff's claim for breach of fiduciary duty, finding the facts fail to show that the defendants breached their fiduciary duty by defaulting plan participants into a managed account.

Background

The plaintiff is a former plan participant representing a class of current and former plan participants and beneficiaries of an employer-sponsored 401(k) retirement plan. The defendants include the plan sponsor, the plan administrator and the plan itself. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The defendants provided employees with a 401(k) retirement plan they would need to opt into. If the employees failed to opt into a different 401(k) plan, they would default into a qualified default investment alternative (QDIA) managed account operated by an outside insurance company serving as the plan's recordkeeper.

The plaintiff alleges that the managed account required participants to pay significantly higher administrative fees than other QDIA plans, such as target-date funds (TDFs). Further, the plaintiff alleged that the plan's yearly administrative fee per participant was over $300, calculating this fee by combining the $24 recordkeeping fee and additional program fee. The plaintiff compared the managed account's cost with the administrative fees for five other allegedly similarly situated TDFs. The administrative fees for the other TDFs were between $34 and $44 per participant, not including any other underlying investment fees or other costs associated with the plans. The plaintiff uses these alleged facts to argue that the defendants (1) violated their duty of prudence by automatically defaulting plan participants into the managed account, which charged excessive administration fees, and (2) failed to properly monitor trust investments in light of these excessive fees.

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

Decision: A former 401(k) plan participant's fiduciary breach claim is dismissed because the participant failed to provide evidence or a meaningful benchmark to demonstrate that the plan's QDIA managed account charged excessive fees.

Arguments and Discussion

The court first addresses the plaintiff's claim that the defendants breached their duty of prudence. The duty of prudence requires a fiduciary to act with the care, skill, prudence and diligence that a prudent person in the same capacity and familiarity with such matters would. For a claim of breach of the duty of prudence under ERISA to be viable, the plaintiff must show direct facts that demonstrate a deficient fiduciary process or circumstantial facts showing that the fiduciaries' decision was outside the range of reasonable judgments that a fiduciary could make based on their expertise and experience. In a suit for excessive fees, the plaintiff must also demonstrate a meaningful benchmark to use as a point of comparison to determine whether the cost was excessive in relation to the service that was provided. The plaintiff should also show that the fees charged were unreasonable in light of the available alternatives.

The court finds that the plaintiff's complaint should be dismissed because the complaint (1) fails to plausibly allege a meaningful benchmark that shows the managed account's fees were excessive in relation to the services that were provided, and (2) compares the managed account's over $300 administrative costs, which includes both the $24 administrative fee and the program fee, against only the administrative fees of the TDFs.

First, the court addresses the plaintiff's comparison of the managed account to the five TDFs, claiming that if the managed account is not per-

sonalized, then the asset allocations between the managed account and the TDFs are comparable. The court points out that the plaintiff's comparison fails because the complaint does not allege specific facts to demonstrate that the services provided by the managed account and the TDF are comparable. The court determined that without specific facts showing the similarity of both plans, the plaintiff failed to allege a meaningful benchmark to show that the managed account's fees were excessive.

Next, the court addresses the plaintiff's comparison of the managed account's administrative costs against the administrative fees for the TDFs. The court notes that the plaintiff combines the managed account's administrative fee and program fee to total $348 but fails to provide information about other account fees charged to the TDFs, instead stating that the administrative fees for the TDFs are only $34-$44 per person. The court equates this to being an "apples to oranges" comparison because the plaintiff includes the program fees for the managed account in its administrative fees and does not do the same when calculating administrative fees for the TDFs. The court finds that the plaintiff fails to provide any meaningful benchmark that would allow the court to assess whether there was a breach of fiduciary duty and that a statement that the managed account's fees are "too high" is not enough. The court thus dismisses the plaintiff's claim for breach of fiduciary duty. The court also dismisses the plaintiff's claim for failure to monitor trust investments because a valid failure to monitor the claim requires an underlying breach of fiduciary duty, which has already been dismissed.

Accordingly, the court grants the defendants' motion to dismiss and dismisses the plaintiff's complaint with leave to file a second amended complaint.

Hanigan v. Bechtel Global Corporation, No. 1:24-cv-00875 (E.D.Va., October 18, 2024).

Federal Court Affirms Decision

continued from page 47

plaintiff's disability statement did not mention any back or neck conditions, and the board explained that it did not review these conditions because they were not included in the statement. Therefore, the court finds no error in the board's determination not to include the plaintiff's neck and back conditions in her disability claim.

The court then addresses the plaintiff's argument that the board erred by failing to consider the additional evidence she provided during her petition for review. The additional evidence included separation letters, a Social Security disability document, two medical reports, a services agreement with a stress and anxiety disorder specialist, bills for therapy sessions and receipts for anxiety assistance services. The board chose not to consider this evidence because it was new and not material. The plaintiff submitted two additional separation letters, which the board also found were not new because they predated the close of the petition for review and were, therefore, not new evidence. The plaintiff submitted additional documents from the Social Security Administrator, which the board found was new but not material because it did not specifically identify medical conditions.

The court agrees with this determination, finding that the absence of medical information provided by the Social Security Administration supported the board's decision that the documents were not material. The board considered the plaintiff's remaining submissions of medical reports, services agreements and receipts to help with anxiety, which were not new—hence, the decision not to consider them in the determination of the petition for review. The court agrees with the board's findings that the plaintiff's submissions were not material or new and finds that that the submissions support the board's decision.

Accordingly, the court affirms the decision to deny the plaintiff's petition for review of her disability benefits denial, finding that her additional evidence was not new or material and her arguments unpersuasive.

Thurston v. Office of Personnel Management, No. 24-1519 (Fed. Cir. Ct., November 15, 2024).

Life Insurance Benefits Claim Rejected Due to Failure to Exhaust Administrative Remedies

The U.S. District Court for the Western District of Louisiana grants the defendant employer's motion for summary judgment in a suit for the award of optional life insurance benefits, finding that the plaintiff failed to exhaust administrative remedies.

Background

The plaintiff is the estate of a former participant of an employer-sponsored group health plan. The defendants are the employer, as plan sponsor and administrator of the benefits under the plan, and the plan itself. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The former participant was a part-time employee and was automatically enrolled in the plan. The employer also offered her optional life insurance benefits along with health and welfare benefits. To enroll in the optional life insurance benefits, the plaintiff was required to pay premiums for the benefits. Though eligible, the plaintiff did not opt to participate in the optional life insurance benefits. The plaintiff passed away, and her estate now brings this claim against the defendant employer for failure to honor its contract for optional life benefits.

Arguments and Discussion

Generally, a claimant seeking benefits from an ERISA-governed plan must exhaust all available administrative remedies before bringing a suit to recover any benefits. The defendant employer presents two arguments in support of its motion for summary judgment: (1) the plaintiff failed to exhaust administrative remedies, and (2) the alleged life insurance benefit coverage is preempted by ERISA, and further, the plaintiff did not elect the optional life benefits coverage or pay the required premiums.

In its review, the court highlights that the plan provides that no legal action may be brought until all steps in the appeal process provided in the plan have been exhausted. Before the plaintiff filed this suit, the plan's administrator had not denied the plaintiff's claim for benefits, nor had the plaintiff pursued an appeal under its appeal provisions. For this reason, the court determines that it lacks jurisdiction over the case due to the plaintiff's failure to exhaust the administrative remedies required by the plan. Additionally, the defendant employer contends that the lawsuit should be dismissed because the plaintiff never elected life benefits nor paid premiums for them. For this reason, the court also concludes that the plaintiff's claims must be dismissed.

Accordingly, the court grants the defendant employer's motion for summary judgment and dismisses the plaintiff's claims with prejudice.

Nyola Lynette Broussard Succession v. CVS Health Solutions LLC, No. 2:23-CV-01138 (W.D.La., October 10, 2024).

BENEFIT DENIAL

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

Decision: A lawsuit filed by the estate of deceased health plan participant seeking the award of optional life insurance benefits is dismissed because the estate failed to exhaust its administrative remedies, and the participant never elected or paid premiums for life insurance coverage.

Court Weighs Proper Forum in Welfare Benefits Suit

BENEFIT DENIAL

The U.S. District Court for the District of Utah grants the defendants' motion to transfer venue in a suit for the denial of benefits after treatment.

Background

The plaintiff includes a participant who is covered by an employer-sponsored group health plan and his covered dependent child. The defendants include the third-party insurance company that administers the benefits under the plan, the plan sponsor and the plan itself. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff dependent received medical care and treatment at a ranch located in Utah. The defendant administrator initially denied coverage for said treatment because the ranch was under a temporary suspension of authorization, automatically denying any claims for services by the facility. The determination to deny coverage was made outside of Utah. The plaintiffs further appealed the defendant administrator's denial to cover benefits, and the defendant subsequently denied the appeals twice. The defendant administrator's correspondence detailing the denial decision letters went straight to the plaintiff dependent's providers in Utah. However, the individuals who made the denial decisions in response to the plaintiffs' various appeals were not located in Utah. No coverage decisions were made in Utah.

This case centers on the appropriate venue, and the facts are relevant to the court's determination. The defendant plan sponsor is a Delaware corporation whose principal place of business is in New York, though it administers the plan in Charlotte, North Carolina. The defendant administrator is a Connecticut corporation, with its principal place of business in Connecticut, and claims for mental health benefits under the plan are managed by a subsidiary, whose principal place of business is in California.

The plaintiffs filed this suit in Utah for recovery of benefits, and the defendants now file a motion to transfer venue, arguing that the Western District of North Carolina is the more appropriate venue because it is closer and more convenient for all parties.

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

Decision: Venue for a recovery of benefits suit will be transferred from Utah to the Western District of North Carolina where the relevant witnesses and documents are located.

Arguments and Discussion

The court has broad discretion to grant a motion for a change of venue. Factors considered in the decision to grant a change of venue include the plaintiffs' choice of forum, accessibility of witnesses, whether the action could have been brought originally in the proposed district, and concerns regarding conflict of laws and enforceability of judgment if one is obtained, among other factors. The threshold inquiry is whether the action could have originally been brought in the proposed transfer district. In an ERISA action, a claim may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be located. Since there is no dispute that the action is proper in the current venue of Utah, the court moves on to address whether the Western District of North Carolina or the District of Utah is a more appropriate forum.

To determine whether a case should be transferred for fairness and convenience, the court primarily considers factors such as the plaintiff's choice of forum, the accessibility of witnesses and the enforceability of a judgment. First, in evaluating the plaintiffs' choice of forum, the court notes that it typically does not defer to a plaintiff's forum choice when the only connection to the forum is the location of the plaintiff's treatment. The court

further clarifies that the facts underlying the claim, rather than the plaintiff dependent's treatment location, determine the appropriate forum. In cases involving benefits claims, the court emphasizes that the focus is on reviewing the administrator's denial of benefits, and it is the denial itself—rather than where the treatment occurred—that determines the relevant forum. Therefore, the location where the administrator decided to deny benefits is the relevant factor in determining the venue.

Here, the plaintiff dependent was provided treatment in Utah, but the court found that this was the only connection to the forum. None of the parties live in Utah, the plan was not administered in Utah and the determination to deny the benefits was also not made in Utah. The plaintiffs allege that the defendant administrator can be found in Utah due to the extensive number of employees and members in Utah and the requirement for the plan's members to send claims to a physical address in Utah. The crux of the plaintiffs' argument is that because of the defendants' business connections in Utah, Utah would be the most appropriate venue, even though the business connections are unrelated to the case. The court disagrees with the plaintiffs' argument that Utah is the most appropriate venue because there is an absence of a material relationship between Utah and the current case. While Utah may be a proper venue, the court disagrees that it is an appropriate venue because the facts that give rise to the claim are not meaningfully connected to Utah.

Next, the court assesses the accessibility of witnesses to determine which forum is most appropriate. Generally, the convenience of witnesses is one of the most important factors in deciding a motion. However, in an ERISA case, it is not, because the court's review is limited to the administrative record. The relevant witnesses and documents involved in the plan's administration are located in North Carolina, where the plan was administrated. Additionally, the relevant witnesses and documents involved in the plaintiffs' claim denials are also in North Carolina. Despite the plan being administered in North Carolina, the plaintiffs argue that Utah is still the preferred venue because the plaintiffs' counsel gathered relevant medical records and documents in Utah to determine the medical necessity of the plaintiff dependent's treatment. The court doesn't find this argument on point because, under ERISA, the critical issue is where the benefits determination and administration of the plan occurred and not where the prelitigation appeal record was created. The court states further that agreeing with the plaintiffs' argument would mean that all ERISA cases must be heard where the plaintiffs' counsel is located. Finally, the court analyzes the ability to enforce the judgment, docket congestion and other practical considerations, and each factor supports the determination that North Carolina, rather than Utah, is the most appropriate venue.

Accordingly, the court grants the defendants' motion to transfer the venue to North Carolina because it is the most appropriate forum, given the facts that brought rise to the claim.

M.H. v. United HealthCare Insurance Company, No. 2:23-cv-00646 (D.Utah, September 20, 2024).

Washington Update

DOL Announces Changes Simplifying the Voluntary Fiduciary Correction Program

On January 15, 2025, the U.S. Department of Labor (DOL) Employee Benefits Security Administration (EBSA) released final rules updating its Voluntary Fiduciary Correction Program (VFCP). This update will provide employers and plan officials with a more streamlined process when voluntarily correcting compliance issues in employee benefit plans. The most significant change is the addition of a self-correction feature for certain delinquent participant contributions and small-dollar amount loan repayments. The final rules will also allow employers and other plan officials to fix mistakes related to participant loans from retirement plans.

Background

The VFCP is a correction program that allows plan sponsors and fiduciaries to avoid civil penalties and enforcement actions under the Employee Retirement Income Security Act (ERISA) if they voluntarily correct certain prohibited transactions in accordance with the steps for correction set out by the VFCP. Prior to this update, the VFCP required employers to submit a formal application for relief to the DOL before a late participant contribution or loan repayment could be corrected. Delinquent participant contributions are the most frequently corrected transaction through the VFCP, and the new self-correction feature will allow plan sponsors and fiduciaries to correct these common errors more efficiently.

2025 VFCP Update

Self-Correction Component

The plan or plan sponsor must not be "under investigation" in order to use the self-correction component (SCC). Delinquent participant contributions and loan repayments will be eligible for the SCC if:

- Lost earnings (calculated from the date of withholding or receipt) equal $1,000 or less, as determined using the VFCP online calculator
- Delinquent amounts are remitted to the plan within 180 days from the date of withholding or receipt.

Plan sponsors seeking to use the SCC also must file an electronic notice on the DOL website that includes the following information.

- Plan sponsor's name and email address
- Plan name
- Plan sponsor's employer identification number (EIN) and the plan's three-digit number
- Type of participant loan failure
- Loan amount
- Date the failure was identified and the date it was corrected
- Correction method
- Number of participants affected by the correction

Plan sponsors must also complete a record retention checklist (provided by the DOL). They must prepare and attach various documents, including proof of the corrective payments, and sign a penalty of perjury statement.

Under this final rule, plan sponsors should be aware that they will still be required to report delinquent participant contributions on the plan's annual Form 5500.

Self-Correction for Participant Loan Transactions

In addition to the SCC, the updated VFCP program will allow the use of the self-correction feature for certain inadvertent participant loan failures that are eligible for self-correction un-

der the Employee Plans Compliance Resolution System (EPCRS). Unlike delinquent participant contributions and loan repayments, where a plan or plan sponsor must not be "under investigation" to participate in the SCC, certain eligible inadvertent participant loan failures may still be eligible for correction, even if the plan or plan sponsor is under investigation. Such loan failures include, but are not limited to, the failure to adhere to plan terms about the number of loans available, improper loan amount and duration, and the failure to withhold participant wages resulting in loan default.

This final rule amending the VFCP will go into effect on March 17, 2025.

The final rules can be accessed at www.federalregister.gov/documents/2025/01/15/2025-00327/voluntary-fiduciary-correction-program.

foundation | news

National Employee Benefits Day: Future-Ready Financial Well-Being

Employee Benefits Day

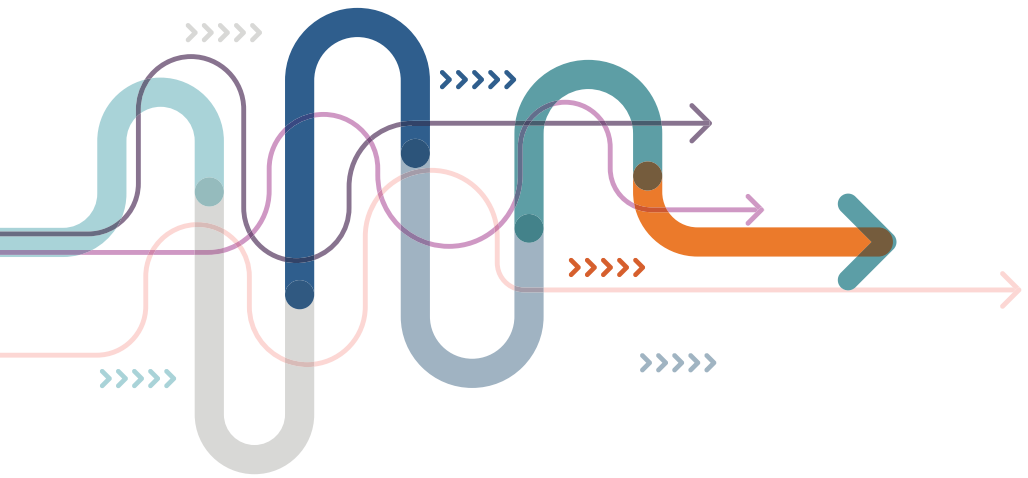
Money matters are a perennial source of stress for many workers, and recent economic conditions, such as inflation and high interest rates, have contributed to anxiety about finances.

Many employers and plan sponsors already make worker financial well-being a priority, but it may be time to take a fresh look at these programs to ensure that they address emerging needs. What role could artificial intelligence (AI) and other new tools play in financial education? How can programs be designed to address the unique needs of low-income workers or employee caregivers?

Get ideas for your financial well-being offerings during **National Employee Benefits Day**, which takes place on **April 2, 2025**. The International Foundation is providing tools and resources to help address many facets of financial well-being. Visit www.ifebp.org/benefitsday to find:

- Ideas to implement in workplace financial wellness programs
- The latest information on financial challenges faced by lower income workers, women and caregivers
- Strategies for using AI and technology in financial education
- Shareable information for plan participants.

The International Foundation will also host a free webcast on April 2.



Coming Up

Health Care Management Conference
April 28-29, 2025
Fort Myers, Florida

Find out what current and future trends will impact health plan costs through hands-on, practical sessions at the Health Care Management Conference. Presentations will address topics including the role of artificial intelligence in health benefits, the state of the union of GLP-1 drug coverage, providing care for an aging population and supporting women in the workplace.

Visit **www.ifebp.org/healthcare** to view the conference agenda and register.

Nominate a Colleague for the Young Professionals Scholarship

The International Foundation is now accepting applications for its Young Professionals Scholarship program.

The program will award six scholarships to cover the cost of conference registration* to the winners' choice of the U.S. Annual Employee Benefits Conference, the ISCEBS Employee Benefits Symposium or the Canadian Annual Employee Benefits Conference. Visit **www.ifebp.org/youngprofessionals** for details. Completed applications are due August 1, 2025.

**Travel and hotel expenses are not covered by the scholarship. The scholarship does not cover the conference registration of the nominator.*

plan | ahead

March 2025

31-Apr 1 35th Annual Art & Science of Health Promotion Conference—Preconference
Scottsdale, Arizona

April 2025

2-4 35th Annual Art & Science of Health Promotion Conference
Scottsdale, Arizona
www.**ifebp.org**/healthpromotionconference

28-29 Health Care Management Conference
Fort Myers, Florida
www.**ifebp.org**/healthcare

30-May 1 Investments Institute
Fort Myers, Florida
www.**ifebp.org**/investments

May 2025

12-15 Portfolio Concepts and Management
Philadelphia, Pennsylvania
www.**ifebp.org**/portfolio

19-20 Washington Legislative Update
Washington, D.C.
www.**ifebp.org**/washington

June 2025

21-22 Trustees Institute—Level II: Concepts in Practice
Nashville, Tennessee
www.**ifebp.org**/trusteeslevel2

22 Trustees and Administrators Institutes—Preconference
Nashville, Tennessee

23-25 Advanced Trustees and Administrators Institute
Nashville, Tennessee
www.**ifebp.org**/trusteesadministrators

23-25 New Trustees Institute—Level I: Core Concepts
Nashville, Tennessee
www.**ifebp.org**/newtrustees

23-25 Accounting and Auditing Institute for Employee Benefit Plans
Nashville, Tennessee
Virtual option available
www.**ifebp.org**/accounting

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

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—Preconference
Austin, Texas

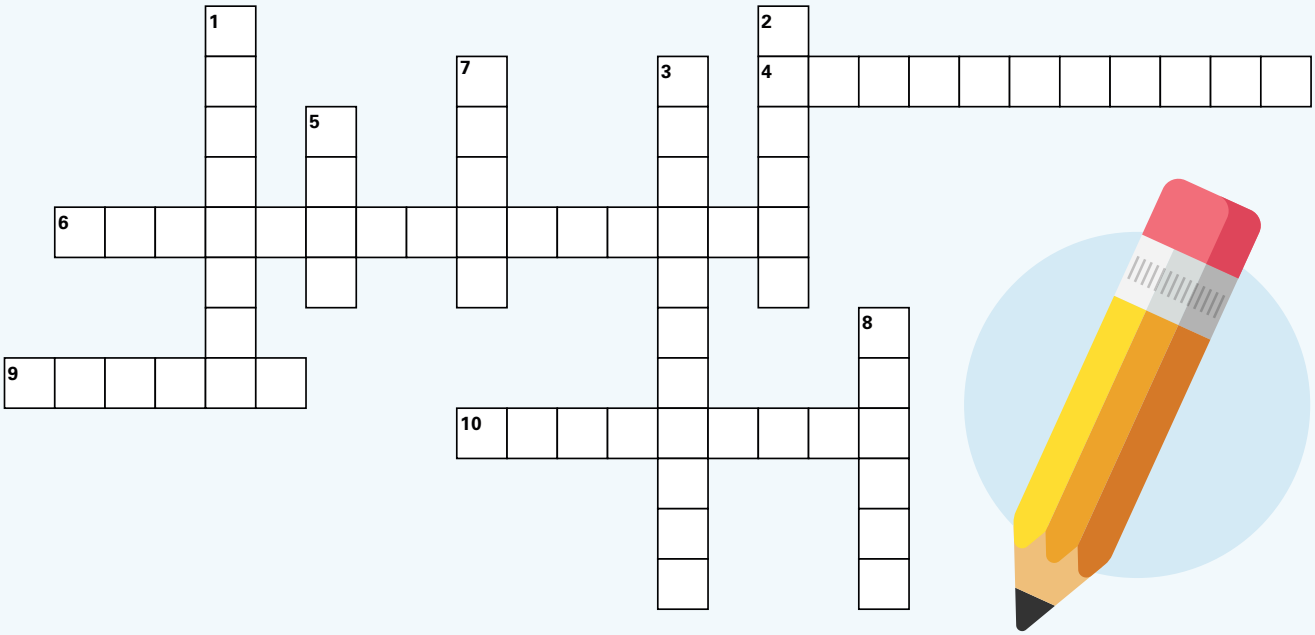
19-21 Annual Wellness Summit
Austin, Texas
www.**ifebp.org**/annual-wellness-summit

[schedule subject to change]

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

benefit fringe | *Benefits Magazine* crossword

Time to get out a pencil and flex your brain power! If you read this issue of *Benefits Magazine,* this crossword puzzle should be a breeze. Just in case, however, the answers are provided at the bottom of the page.



Across

4. Statute of_____
6. A benefit of investing in real estate
9. _____ 2.0
10. To repay an employee who has spent money, e.g., on tuition

Down

1. Nonlocal construction worker
2. Category of weight-loss drug
3. Rules that prohibit reductions or elimination of accrued benefits
5. President who signed LMRA amendment allowing ERISA welfare fund to offer housing assistance
7. Month of National Employee Benefits Day
8. To violate one's fiduciary duties

Answers: 1. Traveler, 2. GLPone, 3. Anticutback, 4. Limitations, 5. Bush, 6. Diversification, 7. April, 8. Breach, 9. SECURE, 10. Reimburse

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