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benefits

MAGAZINE



Confronting the Cost of Obesity Drugs

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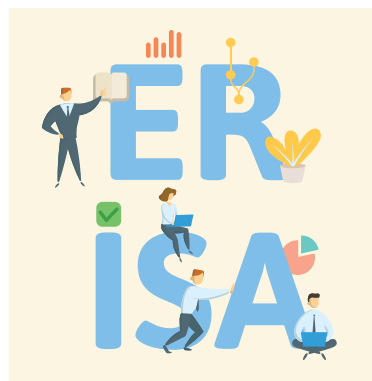
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contributors

Whether it was on a television commercial or a celebrity gossip site, most people have likely heard about the weight-loss benefits of a class of drugs called GLP-1s. While GLP-1s are highly effective at driving weight loss, they are expensive, leaving health plan sponsors wondering how they can afford to cover them. **Jeff Levin-Scherz, M.D.**, and **Chantell Sell Reagan, Pharm.D.**, provide details on the effectiveness and cost of these drugs and offer seven strategies for plan sponsors to consider. Levin-Scherz is a managing director and population health leader of the North American health and benefits practice at WTW, where Sell Reagan is a director and national pharmacy practice clinical lead.

The question of how to handle pension benefits is often the first issue that comes to mind when retired workers come back to work. But another big question is how to address their health care benefits, attorney **Paul Catenacci** contends. Catenacci, who is a senior partner at Novara Tesija Catenacci McDonald & Baas PLLC, describes the health plan compliance issues raised by returning retirees.



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p 20

Employers are increasingly recognizing how the menopause transition can impact women in the workplace, and many are implementing a variety of benefits to help ease the transition. **Lana M. Saal, Ed.D., MCHES, CWP, CHWC**, chief executive officer of the VitHealthity Group, suggests steps for employers that are considering providing menopause benefits and offers ideas for potential benefit changes. Saal is president of the board of directors for the National Wellness Institute (NWI) and is a recipient of the NWI Circle of Leadership Award.



p 26

The time and administrative work required for registered apprenticeship programs (RAPs) to become accredited may seem overwhelming, but consultant **Patrick Rome** explains that the benefits associated with accreditation can be worth the effort. Rome, who owns Rome Consulting in Tempe, Arizona and Minneapolis, Minnesota, outlines the necessary steps to becoming accredited, the challenges RAP funds should consider and the advantages accreditation offers.

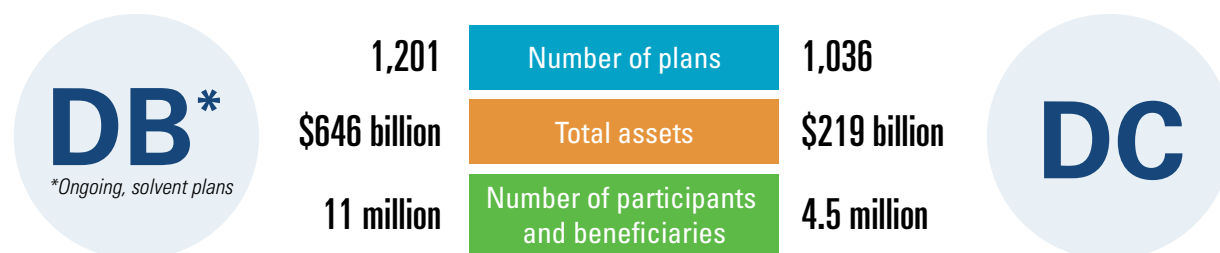


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quick look

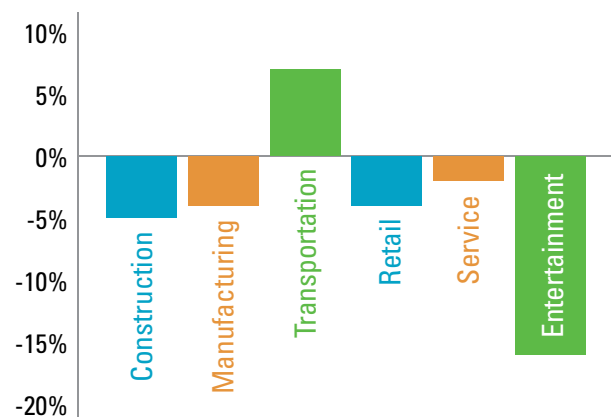
the multiemployer retirement plan landscape 2006-2020

The number of employers contributing to multiemployer defined benefit (DB) pension plans declined in most industries in 2020 due to the COVID-19 pandemic. However, it appears that the initial effects of the pandemic on work levels—and therefore contributions—were outweighed by strong market returns for many plans. Those are among the observations in *The Multiemployer Retirement Plan Landscape: 2006-2020*, a new report by Horizon Actuarial Services, LLC, and the International Foundation. In its ninth edition, the report provides benchmark data on multiemployer DB and defined contribution (DC) plans for the 15-year period ending in 2020. The report will be available at www.ifebp.org/research. Highlights include the following.



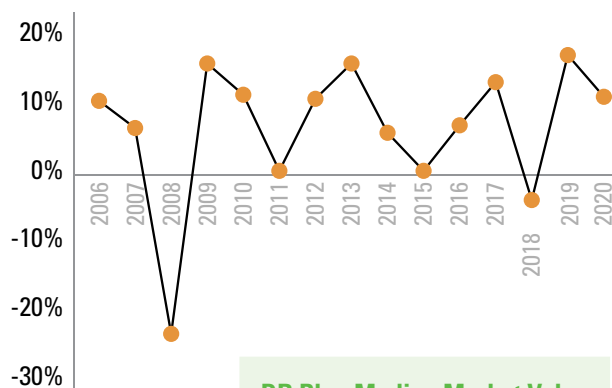
Total Number of Contributing Employers: Percentage Change From 2019 to 2020

Multiemployer Defined Benefit Pension Plans



Source: 2019-2020 Form 5500 data.

DB Plan Median Net Investment Returns

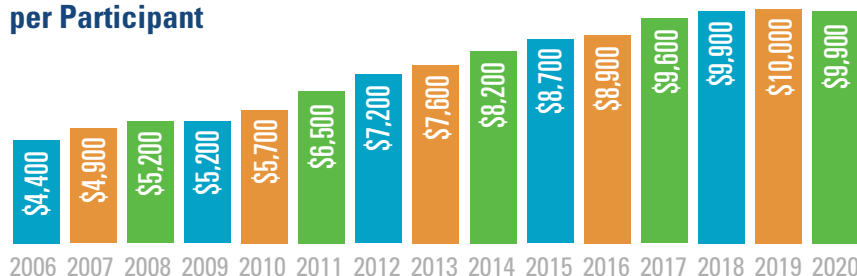


DB Plan Median Market Value Percentages (End of Year)

2005 **87%** 2020 **96%**

Calendar year plans only.
Source: Form 5500 data.

Median DC Plan Employer Contributions per Participant



Source: Form 5500 data.

Median Average End-of-Year DC Plan Account Balance

2006 **\$23,400**
2020 **\$54,100**

conversation

with
Stephanie Chiodi, CEBS



"Employees have physically and emotionally demanding jobs. In today's rapidly changing and dynamic health care environment, employers on a global scale must continually explore innovative strategies to enrich benefit offerings, focused on the needs of plan participants while effectively managing costs," said Stephanie Chiodi, CEBS, a human resources professional who formerly managed health care benefits at Memorial Sloan Kettering Cancer Center (MSK) in New York. During the onset of the pandemic, the hospital found a positive reception to virtual care and leveraged that reception to introduce virtual physical therapy for its employees. Chiodi shared the details of the organization's strategy with editor Tim Hennessy and discussed the return on investment for the initiative as well as the outlook for virtual care.

Stephanie Chiodi, CEBS

Director, Benefits,
Moelis & Company,
New York, New York

What caused your organization to reexamine its benefits strategy?

During my time at Memorial Sloan Kettering Cancer Center, our health care plan experienced a substantial rise in expenses within the musculoskeletal category, encompassing costs associated with conservative care—approaches individuals employ to manage daily pain, such as chiropractic care, acupuncture, physical therapy and pain management techniques like cortisone injections. Additionally, prescription drugs for pain relief contributed to this increase. Moreover, our data revealed a significant surge in the occurrence of joint replacement surgery and ligament reconstruction surgery, both of which impose considerable financial impact on the health care plan and require extensive commitment from the plan participants for optimal recovery.

How did your organization approach addressing this issue?

To achieve our objective of fostering a health care plan that realizes timely care for plan participants while also focusing on cost management, we recognized that the inclusion of virtual physical therapy represented a distinct and valuable enhancement to our health care plan. This inte-

gration yielded a multitude of advantages for both the plan sponsor and the plan participants.

Our focus was to identify a vendor to deliver personalized experiences for our plan participants and ensure that clinicians were readily available for one-on-one interactions as frequently as participants required. It was crucial to find a vendor that recognized the profound connection between mental and physical health, particularly in our caregivers who might be grappling with chronic pain while working in a compassionate environment. Finally, we placed a high premium on the vendor's ability to work with secure, efficient and reliable technology that could serve plan participants across the country.

Once we identified a vendor we believed would surpass our expectations and completed the onboarding process, we introduced our new benefit during our annual enrollment season. At that time, the leading contributors to medical plan costs were lower back pain followed by shoulder and knee pain—chronic conditions that would not naturally improve. We were optimistic that plan participants would embrace this benefit. We framed it as a comprehensive approach to physical therapy, designed to ensure that plan participants have equitable access to high-value physical therapy care that is available around the clock and

comes at no cost to them (no copayment or cost sharing). This was especially beneficial for those with busy schedules, as it alleviated the logistical challenges of making multiple weekly visits to a traditional physical therapy office for eight to ten weeks, a typical time frame for a standard physical therapy protocol.

Could you describe the user experience?

The user experience was crucial for successful benefit integration. The experience needed to be personal and seamless, so much so that the sessions would become a regular part of their weekly routine.

During the intake process, participants identify their physical needs, medical background, preferences in provider and other preferences like mode of communication. They are matched with a doctor of physical therapy based on their medical need. As the intake process occurs, the vendor receives a kit at their home that includes a tablet that connects to Wi-Fi and, depending on their care program, sensors that may be worn during sessions. Following a virtual meeting with their care provider, participants utilize the tablet to follow specific movements and exercises. The tablet and/or the sensors read the movements, record biometric data and correct movement as needed using visual and auditory signals. Each session usually includes multiple different types of exercises, which can be completed in 15 or 20 minutes. The participant provides feedback on their pain level and experience after a session.

Participants engage with their physical therapists throughout the week through chat, phone or video conference if needed. Behind the scenes, their therapist reviews their biometric data and feedback from sessions and makes adjustments as needed. When participants begin their next session, they may find the exercises have changed to accommodate their health journey.

Once the participant completes their initial physical therapy protocol, they may continue to perform exercises through the tablet or the vendor's smartphone app.

How was success measured?

After a year of active engagement, I had the opportunity to comprehensively assess the effectiveness of our benefit.

This involved thoroughly analyzing performance and quality scores and reviewing experience claims data from our medical and pharmacy benefit plans.

Some insights gained from this analysis:

- Over 64% of our participants who utilized our virtual physical therapy benefit engaged in their sessions after traditional physical therapy offices typically closed for the day. This effectively fulfilled our requirement of delivering care precisely when plan participants wanted to engage.
- On average, our plan participants adhered to their physical therapy protocols, completing an average of three sessions per week over a full eight-to-ten-week treatment protocol. This level of engagement exceeded the performance data seen in traditional physical therapy, where our plan participants typically completed an average of nine visits in total within the same eight-to-ten-week period.
- Seventy percent of participants reported feeling better and regaining their ability to carry out daily living without impairments. They also demonstrated a reduced reliance on medications for pain management, as evidenced by their patient evaluations and our clinical pharmacy data.
- Suffering from chronic pain can have a detrimental impact on one's mental well-being, often leading to elevated rates of reported depression and anxiety. It's noteworthy that more than 80% of plan participants reported experiencing a positive influence on their psychological health, as evidenced by aggregated GAD-7 scale scores (a widely employed clinical tool for screening and assessing the severity of generalized anxiety disorder) and aggregated PHQ-9 scale scores (a commonly used screening tool for evaluating the severity of depressive symptoms and diagnosing a major depressive disorder).
- Three of our medical plans experienced a notable reduction in musculoskeletal claim expenses, covering surgeries/procedures, acute care and pain management. Meanwhile, our other plans displayed a less significant increase in expenses than initially forecasted at the outset of the plan year.

How can introducing this benefit impact a plan?

Integrating virtual physical therapy can be a progressive and valuable addition to health care plans, offering plan participants high-value care in a cost-effective and easily accessible manner. Furthermore, it can play a pivotal role in an organization's strategic approach to effectively deliver a comprehensive path to care and manage the escalating costs associated with musculoskeletal medical claims.

What are the challenges of integrating virtual physical therapy into benefit plans?

My team and I needed to find dynamic ways to remove barriers to care for physical therapy needs. While virtual physical therapy can provide substantial benefits, it may only suit some plan participants or some medical condi-

tions. Furthermore, although virtual care has been more widely accepted since the pandemic, and in many cases is a preferred modality of care, a significant population does not trust the level of care or prefer the experience.

What should employers consider when evaluating the inclusion of virtual physical therapy?

Plan sponsors should carefully consider the initial investment and commit to robust communication, as participant engagement is pivotal in realizing the cost-saving advantages of a virtual physical therapy benefit. In my opinion, it is essential to consider how the vendor aligns with the organization's culture and ensure you are selecting a partner prepared to support employees and their covered dependents during an often challenging health journey.



heard on community

bereavement leave

The topic of paid bereavement leave gained heightened attention during the COVID-19 pandemic as more employers looked for ways to support grieving workers. Nearly 90% of organizations offer paid bereavement leave, but the number of days varies, according to *Paid Leave in the Workplace: 2024 Survey Report*, a recent International Foundation report. The question of how to administer paid bereavement leave and how many days to offer generated several responses recently on Foundation Community.

the question

With more states adopting bereavement leave laws, how does your organization administer bereavement leave? How many days of leave do you provide to your employees? Is there a set number of leave days that an employee is eligible for based on the relationship to the deceased family member? Is the leave paid or unpaid? Also, does your organization require any type of documentation? If so, what type of documentation?

the conversation

If the deceased is a spouse, domestic partner or child under the age of 26 (including stepchildren or child of domestic partner), the company grants the employee up to 80 hours of paid leave. If the deceased is a child age 26 or older or other family members defined as a parent, sibling, grandparent, grandchild and similar steprelatives, in-laws and close family members of domestic partners, the company grants the employee up to 40 hours of paid bereavement leave.

We have three paid days of bereavement leave for immediate family and one paid day for all other family/friends/etc. We do have employees in states that mandate longer bereavement leaves, so they are given what the state/locality entitles them to.

We offer five days of paid bereavement leave, and the employee can use their PTO if they need to extend for more days. In the event that it is a more delicate situation where the employee needs time off for mental health reasons, they can file to take a medical leave up to 12 weeks, which does have company paid time (with proper medical certification) under either FMLA or state leave eligibility requirements.

Employees may be asked for a copy of documentation of the death within 30 days of the first day of bereavement time off request. (Many forms of documentation are acceptable when taking a bereavement leave, including a death certificate, a published obituary, written verification of death and notices of burial or celebration of life/memorial services from a funeral home, burial society, crematorium, religious institution or governmental agency.)

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



Confronting the Cost of Obesity Drugs

by | **Jeff Levin-Scherz, M.D.**, and **Chantell Sell Reagan, Pharm.D.**



Effective weight-loss medicines—referred to as GLP-1s—represent a huge clinical advance, but health plan sponsors find them hard to afford. Learn what strategies health plans are using to meet the demand for these drugs while mitigating the high price tag.

The rising rate of obesity in the United States and throughout the developed world has led to an increased occurrence of diabetes, heart disease, kidney failure, musculoskeletal disease and certain types of cancer. Health plan sponsors, employers, public health leaders and people with obesity have long sought an effective approach to weight loss, but the only long-term effective treatment has been bariatric surgery.

Glucagon-like peptides—medications referred to as GLP-1s—have changed this dynamic. These drugs are highly effective at driving weight loss, but they are extremely expensive. This class of drugs has been used to treat diabetes since 2005, but the first weekly injection labeled specifically for obesity was not approved until 2021. Plan sponsors may want to provide coverage for these medications but are struggling to address how to afford them. This article will highlight why some employers and plan sponsors are offering coverage and the tactics they are using to address the growing demand for these medications.

The Challenges of Treating Obesity

Our understanding of the causes of obesity has changed dramatically over the last few decades. Both genetic and environmental factors drive the rise in obesity, including the ready availability and low purchase price of calorie-dense, highly processed foods that don't lead to a sense of fullness.

takeaways

- GLP-1 drugs (glucagon-like peptides) are highly effective at driving weight loss but also are extremely expensive. Health plan sponsors that want to cover these medications are struggling with how to afford them.
- GLP-1 drugs were first used to treat diabetes but have the beneficial side effect of causing weight loss. People who take them are less hungry and eat less, but side effects often include nausea and constipation.
- List prices for brand-name GLP-1 drugs approach \$17,000 a year, and researchers estimate that treatment can cost \$274,400 over a patient's lifetime.
- Plan sponsors are using a range of strategies to mitigate the costs of GLP-1 drugs, including covering them for only a subset of plan members with obesity or requiring participation in lifestyle programs or a previous trial with other medications.
- Some plans are shifting more costs to plan members or implementing lifetime maximums or other coverage limitations.

People with established obesity who try to reduce calorie intake face “food noise”—an intense preoccupation with hunger that makes it hard to stay on a diet. Those who succeed in markedly reducing their calories often are thwarted in their effort to lose weight by a slowing metabolism. For instance, most of the winners of the 2009 season's “Biggest Loser” contest on television regained substantial weight despite maintaining a strict calorie-limited diet and exercising many hours a day. Metabolic testing showed that they each burned hundreds fewer calories than would be expected based on their size.¹

Historically, medications to drive weight loss have been only modestly effective and sometimes have led to serious side effects. Phentermine, for example, can lead to a modest amount of weight loss through appetite suppression. The drug was more effective when paired with fenfluramine in the 1990s, but fenfluramine was withdrawn from the market when it was found to sometimes cause fatal pulmonary hypertension and severe heart valve problems. Other drugs, including Contrave® (naltrexone and bupropion), Qsymia® (phentermine and topiramate), and Alli® or Xenical® (orlistat), can lead to weight loss of up to 5% but often have troublesome side effects.

Bariatric surgery leads to sustainable weight loss for many with obesity but requires specially trained surgeons, multidisciplinary teams and highly motivated patients. Current surgical techniques generally lead to 15% weight loss, which substantially decreases risk for obesity-related medical problems. But few people who qualify for bariatric surgery have had it. Only an estimated 1% of those with obesity have had bariatric surgery,² and the demands of this surgery make it unlikely to be an effective way to address obesity at scale across the population.

Enter GLP-1 Drugs

GLP-1 drugs were first used to treat diabetes almost two decades ago. While many drugs that effectively treat diabetes cause weight gain, GLP-1 drugs have the beneficial side effect of causing weight loss. Most GLP-1 drugs are self-administered by injection; the early drugs were used daily much like insulin, and the most effective current drugs, Wegovy® (semaglutide) and Zepbound™ (tirzepatide), are injected weekly. The same GLP-1 drugs are used—sometimes at different doses and generally with different names and prices—to treat both diabetes and obesity. The Food

and Drug Administration (FDA) has approved these drugs for those with a body mass index (BMI) of 30 or a BMI of 27 with a complication such as high blood pressure or high cholesterol. While this group of drugs gained widespread publicity fueled by cosmetic use by Hollywood celebrities, they are not clinically indicated for those who are overweight (BMI between 25 and 30) without other related health conditions.

How They Work

GLP-1 drugs address the underlying causes of obesity. Those on GLP-1 drugs are less hungry due to hormonal changes that affect the satiety center of the brain, and they are able to eat less because the transit time through the stomach is longer. People on these medications who restrict their calories often lose the food noise that made them eat extra calories, and these medications reportedly also often decrease other compulsive behavior, including drug, alcohol and tobacco use.³ The drugs frequently cause gastrointestinal side effects, most prominently nausea and constipation, although these symptoms can diminish over time. They also cause loss of bone density and lean muscle as well as delayed stomach emptying, which can raise the risk of anesthesia complications.

Effectiveness

This class of drugs has been shown to have major clinical benefits in addition to weight loss. Their use is associated with a decreased progression to kidney failure in people with diabetes⁴ and a decrease in the incidence of major cardiovascular events (such as heart attacks and strokes) in both people with diabetes⁵ and obese people with a history of heart disease.⁶ In March 2024, the FDA approved the use of Wegovy to “help prevent life-threatening cardiovascular events in adults with cardiovascular disease and either obesity or overweight.” Both semaglutide and tirzepatide have been shown to reverse metabolic dysfunction steatohepatitis, otherwise known as fatty liver, so they might decrease risk of liver failure.⁷

Some reports⁸ show that as many as two-thirds of people who start GLP-1 medications for obesity are no longer taking them a year later, and some stop less than three months after starting. Some may have stopped due to insurance requirements or drug shortages. Others may have side effects or misaligned expectations. Most patients must continue to take

learn more

Education

Employers' Critical Role in Fighting the Obesity Epidemic On-Demand Webcast

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the drugs continuously to maintain weight loss, though this increases the cost to the plan sponsor. These drugs should not be used intermittently for cosmetic weight loss.

Randomized clinical trials where a portion of those studied is switched from active medication to placebo generally show substantial weight regain after the drug is stopped. That said, average patients do not regain all the weight that they lost. One observational study⁹ of medical records suggested that two-thirds of those who discontinue these drugs continue to lose weight or maintain their GLP-1-associated weight loss, but some portion of the participants might have obtained these medications from other sources outside of their health plan. There are many studies in progress to determine whether discontinuation of the medication combined with an effective diet or lifestyle program can result in maintenance of weight loss after stopping the drug.

Costs

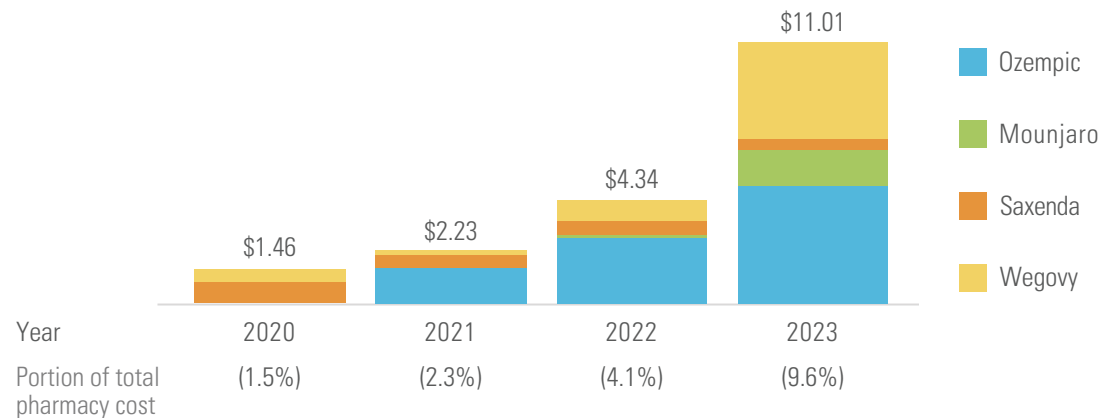
The GLP-1 drugs marketed for obesity are available only in a few countries—including the U.S.—that support relatively high pharmaceutical prices. The annual list price in the U.S. for Wegovy is more than \$17,000 and Zepbound is just under \$14,000. When the costs of GLP-1 medications are spread over the entire plan population, plans are paying about \$11 per member per month for these drugs (See figure). Discounts and rebates reduce the net price to a bit under \$10,000 for each of these medications. Zepbound is available to those without insurance coverage from the pharmaceutical company for \$6,600 a year. An earlier GLP-1 obesity medication, Saxenda, requires daily injections and has a current list price of over \$16,000.¹⁰ Saxenda loses its patent protection in 2024, but generic versions may not be available until 2026.

The GLP-1 drugs can lead to substantially improved health for many and can prevent heart attacks, strokes, the need for kidney dialysis and other serious illnesses. However, studies have shown that these drugs are unlikely to

FIGURE

GLP-1 Costs, 2020-2023

Cost per Member per Month of Selected GLP-1 Medications After Discounts and Rebates



Note: Mounjaro and Zepbound are both the drug tirzepatide. Mounjaro was marketed in 2022 and Zepbound was marketed in late 2023.

Source: WTW Collaborative data on file. Analysis limited to plans that covered GLP-1 medications for obesity.

lower medical costs over any time horizon unless they are sold at dramatically lower prices. For instance, the Institute for Clinical and Economic Review (ICER)¹¹ found that the cost to a plan sponsor for semaglutide over a lifetime would be \$274,400, while the medical costs averted over a lifetime would be \$61,600. A very large study¹² showed that 100 people with obesity would need to be treated for three years to prevent one major cardiovascular event. An industry-funded simulation¹³ showed that 100,000 people treated for five years with the loss of 15% of their body weight would lead to \$85 million lower medical spending. But at current prices, the cost of the drugs would be over \$4.5 billion over five years, so the cost saving is less than two cents per dollar spent on the medications.

WTW research shows that more than one-third of employers (38%) currently cover GLP-1 medications for obesity, although almost all employers cover these drugs for diabetes. Some plan members likely obtain the GLP-1 medications labeled for diabetes to help them lose weight. The survey showed that 10% of employers said that they were covering these medications for only those with a BMI higher than recommended by the FDA, and 26% said they require a medically supervised diet or a trial of less-expensive

antiobesity drugs prior to offering coverage for GLP-1 medications.¹⁴ The total cost to commercial health plans of GLP-1 drugs that can be used for obesity has increased by more than 600% between 2000 and mid-2023, leading to steep increases in total pharmacy costs for many plans that cover these medications.

Employers and Plan Sponsors Respond

Employers and plan sponsors are taking a range of actions to address the costs of GLP-1 medications. These strategies are described below.

1. Implement documentation requirements to prevent use of these medications for cosmetic purposes

Prior authorization with required documentation can decrease the likelihood that drugs are approved for a cosmetic rather than a medically necessary purpose. This approach is being used by a wide range of plans that offer coverage for these drugs. Members who have successfully lost weight with these drugs might not qualify if asked to repeat prior authorization. Plans changing pharmacy benefit managers (PBMs) can seek to transfer previous prior authorization approvals to avoid interruption in treatment.

2. Cover antiobesity medications only for a subset of plan members with obesity

Those who have higher BMIs or a history of cardiovascular disease are more likely to have medical complications from obesity, so these drugs will provide more medical benefit for those with higher risk. Plans seeking to provide the highest value care can restrict coverage to those with a history of cardiovascular disease or set a threshold for coverage that is higher than the FDA-recommended BMI of 30 (or 27 with comorbidities). Such a restriction requires an effective prior authorization process. These drugs have high rebates, and agreements between pharmaceutical manufacturers and PBMs can limit rebates to plan sponsors that provide coverage at the BMI levels as approved by the FDA. Plans considering limiting coverage based on BMI or medical history should ask their PBM or pharmacy consultant to assess the financial impact of this approach.

3. Restrict providers who can prescribe this class of medications

Some plans seek to restrict prescribing based on medical specialty (for instance, endocrinology or primary care), which requires the PBM to restrict to a limited prescriber network. Some vendors offer virtual medical care and obesity-trained providers to use other less expensive alternatives before prescribing GLP-1 medications. Having virtual providers prescribe obesity treatments could lead to fragmentation and undermine efforts to get plan members at risk for chronic disease to develop primary care relationships. Limiting which providers can prescribe GLP-1s could reduce rebates in some instances.

4. Shift more costs to members for medications to treat obesity

Some employers and plan sponsors have considered putting drugs that treat obesity in a special tier with a larger member out-of-pocket responsibility. They should consult with counsel to be sure that such plans are consistent with the Health Insurance Portability and Accountability Act (HIPAA), the Americans with Disabilities Act (ADA) and mental health parity requirements. While the Affordable Care Act (ACA) does not allow annual or lifetime maximums for essential health benefits, these medications are not considered essential health benefits by most state marketplace plans that serve as benchmarks for commercial health plans.

Therefore, plan sponsors could consider shifting costs to members by not applying these drug costs to the out-of-pocket maximum. This approach will likely be more attractive to employers that face less difficulty attracting talent.

5. Implement a lifetime maximum or other coverage limitations for GLP-1 medications to encourage “deprescribing”

Some plan sponsors¹⁵ have announced that they will cap total lifetime coverage for GLP-1 medications for obesity (which would be permitted, as long as the drugs are not ACA essential health benefits). This would mean that plan members would lose insurance coverage for GLP-1s after 18-24

Employer Strategies for GLP-1 Drugs

A November 2023 survey report from the International Foundation (*GLP-1 Drugs: 2023 Pulse Survey*) showed that 27% of respondents provided coverage of glucagon-like peptides (GLP-1s) for weight loss, and 13% were considering covering the medications for weight loss. More than three-quarters (76%) covered the medications for diabetes.

Organizations that cover GLP-1 drugs for weight loss used the following cost-control mechanisms.

- Utilization management: 79%
- Step therapy: 32%
- Eligibility requirements: 16%
- Annual maximum: 5%
- Lifetime maximum: 4%

Fourteen percent of organizations indicated that they had no cost-control mechanisms for the medications.

Following are the four most common options besides GLP-1 medications that organizations said they offered for diabetes and weight loss.

- Disease management/case management programs: 76%
- Nutritional counseling: 63%
- Bariatric surgery: 59%
- Lifestyle modification programs: 51%

Visit www.ifebp.org/GLP1drugs to view the full survey report.



months, at which point they would have to pay out of pocket or go off the medications. Limiting the duration of treatment could worsen health equity since lower wage workers would likely have difficulty affording continued treatment when they reached their coverage limit.

Current clinical evidence suggests that most individuals off GLP-1s would rapidly regain the weight they lost, and some employees might seek to change employers to avoid such a coverage “cliff.”¹⁶

6. Offer or require lifestyle modification programs for management of obesity before or during drug treatment

Many employers and plan sponsors offer comprehensive programs that can include nutritionists, coaches and apps to help people lose weight and maintain weight loss. The FDA recommends that these GLP-1 drugs be used “as an adjunct to a reduced calorie diet and increased physical activity,” and formal programs can support plan members to maintain calorie restriction and increased exercise. Still, some published data suggests that intensive behavioral intervention alone is far less effective than GLP-1 treatment.¹⁷ Some plans are considering requiring participation in a lifestyle program to maintain eligibility for GLP-1 drug coverage or as a step before drugs are prescribed. Plan sponsors should consider the cost of any new lifestyle program and potential loss of rebates when projecting financial implications of GLP-1 coverage. They may also want to consider potential discrimination issues under HIPAA based on what requirements are imposed for initial or continued coverage of these medications.

Many vendors sell programs they say will help individuals transition off GLP-1 medications, but it is too early to assess whether these programs will help most members maintain weight loss without medication. One vendor has shown maintenance of weight loss after GLP-1 discontinuation with a low carbohydrate diet and counseling,¹⁸ and one small research study showed those randomized to a structured and vigorous exercise program regain less weight after GLP-1s are discontinued.¹⁹

7. Do not provide coverage for these medications

The majority of employers (62%) currently do not provide coverage for obesity medications such as GLP-1 medications. Medicare Part D was prohibited from covering weight-loss medications by its initial enabling legislation in 2003. Some plans have reversed prior coverage policies and elected to stop

bios



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covering these drugs for obesity, including several health system plans and state-run employee benefit plans. Members of health plans that provide no coverage for this class of medications for obesity can pay for these medications out of pocket, although few will be able to afford this. One manufacturer offers a steep discount to self-paying customers, but the total cost would still exceed \$6,000 per year. Some plan members will qualify for the diabetes versions of these drugs.

Employers might find that noncoverage will hurt their efforts to recruit and retain talent. It will also decrease health equity since lower wage plan members likely won’t be able to afford the drugs without coverage. Employers that do not cover obesity medications can still cover bariatric surgery, which has a high up-front cost but is less costly for plan members who remain on the plan for over three years.

Conclusion

No other nonsurgical treatment today is as effective in decreasing obesity as the GLP-1 drugs. Long-term use of these drugs appears to be safe and is consistent with our clinical understanding of the metabolic disease of obesity. However, the expense of these medications will mean that a large portion of the population will have limited access for now.

With dozens of related drugs in the pipeline, the per person cost of treatment could decline substantially over the

coming years, which could mean that plan members will get the full medical and social benefits of this effective therapy. Until then, employers have multiple options to mitigate the cost impact of these medications to their bottom line. 📌

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Returning Retirees:

Considerations for Health Plan Fiduciaries

by | Paul Catenacci

Returning retirees can help ease labor shortages, but multiemployer health plan trustees must be aware of the compliance and administrative implications created when a retiree comes off the sidelines.



Retirees returning to work raise a variety of plan design and compliance considerations for trustees of multiemployer health plans. This includes compliance with Medicare Secondary Payer (MSP) rules, how to treat incoming employer contributions for the retiree, possible reinstatement of working retirees to active coverage as well as whether the return to work affects service requirements applicable to retiree coverage when the retiree stops working.

This article will explore these topics and discuss the fiduciary and compliance considerations they present for health plan fiduciaries.

Plugging the Labor Gap

The need for workers has been a recurring theme for just about every industry since the ending of the restrictions put in place due to the COVID-19 pandemic. Yet, perhaps nowhere is the need more acute than in the building and construction industry. An aging population of tradespeople, combined with the backlog of work created by the pandemic as well as new developments driven by government programs and funding, has resulted in many unions and employers turning to retirees to ease temporary or extended labor shortages.

Returning retirees bring not only extra pairs of hands but also years of experience performing and supervising work and crews of workers. They can also serve as an invaluable training and mentoring resource to the next generation of tradespeople who are starting their careers. But their return

raises legal, plan design and operational issues for health plans that require consideration and ongoing monitoring by plan trustees.

Keeping Their Pensions

When retirees return to work, boards of trustees, as well as the retirees themselves, often inquire first about whether the working retirees will continue to receive their pension benefit. Retirees are generally restricted by the defined benefit (DB) plan rules in the number of hours per month they can work while still collecting their pension benefits. This can be low, 40 hours per month in some cases; so if there is a desire to bring retirees back into the workforce, the DB plan trustees will need to consider changes to their “suspension of benefit” rules. This situation requires clear and open communication between the boards of trustees for the health and pension plans in situations where the board makeup is not the same—But the inquiry does not end there.

Trustees of health plans must also consider how retirees returning to work will impact their plans. Considerations are explored in detail as follows.

Incoming Contributions for Retirees—Who Keeps the Money?

When a retiree goes back to work, their employer will be required to remit contributions to the health plan for the hours they work. Absent existing plan rules on this topic, plans will have to set rules to determine who gets to keep that money. There is no right or wrong answer to this question, so each plan will have to decide what works best for that particular plan. For example, some plans direct the contributions to the financial benefit of the plan overall, which means that the retiree (if covered by a retiree health plan) will continue making the monthly premium payment they were making before they came back to work. Other plans may decide to use the employer contributions to benefit the working retiree by offsetting the eligibility premium paid by the retiree with any excess going to the benefit of the plan. Still others may refund the contributions to the retiree, return the retiree to active status or adopt a mix of these options.

Determining which option is best will vary from plan to plan, and like any other decision, designing these rules is a fiduciary function under the Employee Retirement Income Security Act (ERISA). When deciding on a prudent design, health plan trustees must determine what is in the best interest

takeaways

- As a result of the backlog of work created by the pandemic as well as new developments driven by government programs and funding, many unions in the building and construction trades are turning to retirees to ease temporary or extended labor shortages.
- When a retiree returns to work, it raises legal, plan design and operational considerations for multiemployer health plans.
- One question that plan trustees must consider is where to direct employer health plan contributions. Some plans direct them to the good of the plan, use them to offset eligibility premiums paid by the retiree or refund them to the retiree.
- The number of hours retirees work will affect their return to retired status and the application of Medicare Secondary Payer rules.
- Health plan design considerations include how to treat hour banks and service requirements for retiree health coverage.

of the plan and its participants, and this will require the balancing of many factors. For instance, health plan trustees should first consider the financial health of their plan—Is the plan deficit spending or low on cash reserves? In those situations, trustees may well decide that the plan needs this money for the good of the plan, particularly when the retiree is also receiving a DB pension benefit while working. On the other hand, plans in a stable or strong funding position may take a different approach and decide to give the retiree all or a portion of the benefit of the contributions as an additional enticement to come off the bench and go back to work.

Regardless of which way a plan chooses to go, the rules should be clearly laid out in the plan's governing documents; understood by the board of trustees, the salaried plan administrator or third-party administrator (TPA); and clearly communicated to plan participants in a written notice.

Keep a Close Eye on Medicare Retirees

How many hours retirees will work is another issue that trustees must consider. They should ensure that those hours are being tracked and determine what classification the retiree will be given under the plan while they are working. This is critically important for Medicare-eligible retirees, due to MSP rules.¹

The MSP rules prevent plans from “taking into account” a participant's eligibility for Medicare when determining eligibility for coverage. This generally results in Medicare paying *secondary* whenever an employee is eligible to receive health insurance coverage as a result of working.² These

rules will apply to most multiemployer plans, since all it takes is a single contributing employer to the plan to have employed 100 full-time or part-time employees on 50% or more of its regular business days during the previous calendar year to trigger their application.³ In instances where a plan insures its Medicare retirees and self-funds the claims for everyone else, the MSP rules can result in a complete shifting of the claims risk for the working Medicare retiree from Medicare back to the self-funded asset pool of a health plan.

To better understand the MSP rules, let's take a closer look at how the rules work in practice. In a nutshell, this prohibition⁴ means what it says—A plan cannot consider a participant's eligibility for Medicare in its plan design by taking actions such as:

- Failing to pay primary benefits
- Making Medicare-eligible participants wait longer for coverage to begin
- Charging Medicare-eligible participants higher premiums
- Imposing limitations on benefits for the Medicare-entitled individual that do not apply to others enrolled in the plan. Examples of such limitations include providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or being more restrictive on preexisting condition exclusions.⁵

Accordingly, if a Medicare-eligible retiree who is receiving coverage from the plan's Medicare program works sufficient hours to become an active participant in the plan, the retiree would

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have to be treated as an active participant under the plan at least for purposes of coordination with Medicare.⁶ This means at a minimum that the plan—not Medicare—has to pay first, resulting in a shift of primary liability for the claims that the working retiree (and any dependent) incurs.

Moreover, in some settings, the shifting of claims risk can be more dramatic. In recent years, the structure of Medicare and associated subsidies has driven many plans that cover Medicare retirees to adopt fully insured group Medicare Advantage (MA) plans. When a retiree comes back to work and works enough hours to become an active participant in the plan once again, that retiree must move off the MA plan and back onto the active plan. Not only does this result in a complete shift of the claims risk, it also creates an administrative load for the plan since the administrator must track the hours of the working retiree and ensure that they are moved off the MA plan and put back onto the active plan. Health plan trustees should discuss with their plan professionals how this shifting of risk may impact the plan. For self-funded plans in particular, the trustees need to review the potential impact on stop-loss coverage.

Another way in which the MSP rules play a role is how Medicare views extended eligibility. Active participants typically have a way to accumulate eligibility for use when work is slow or when the participant may be laid off. Most plans refer to this mechanism as an “hour bank,” but different terms may also be used. Plan rules on these banks

vary widely, so trustees will need to carefully review the rules in place that affect all participants. If a returning retiree is restored to active status, they would start to accumulate extended eligibility once again. This is very important to consider because Medicare considers banked hours or extended eligibility to be a form of retention of

employment rights.⁷ In other words, Medicare views extended coverage rights or banked hours as equivalent to a retiree still being actively employed. As a result, if a plan permits or requires a retiree to exhaust accumulated eligibility or banked hours before being required to start paying for retiree coverage, Medicare will pay *secondary* during the period that the banked hours are being exhausted. Consequently, a plan’s bank exhaustion feature will operate to extend the period that the active pool bears the risk of claims for Medicare-eligible working retirees after their return to work is over.

But the plan is not alone in being impacted by the way the MSP rules affect working Medicare-eligible retirees. The retiree also will be impacted by moving from one plan of benefits to another. In many cases, the cost-sharing requirements (copays, deductibles and coinsurance), as well as the network and prescription drug coverage, are unlikely to be the same under each plan. Therefore, welfare plan trustees should ensure that retirees are well-informed about how their coverage may change should they choose to return to work. Non-Medicare retirees who are moving from a retiree health plan to active coverage also should be informed of the potential for such changes.

Returning Retiree Checklist

Health plans should make sure to address the following issues related to returning retirees:

- ❑ **Treatment of health plan contributions.** Absent existing rules, the plan must set rules governing treatment of employer health plan contributions made on behalf of the returning retiree. Options range from directing the contributions to the benefit of the plan to refunding the contributions to the retiree. Plans may tinker with novel approaches as well, such as crafting broadly applicable rules that apply equally to all plan participants (for example, adopting a uniform rule on treatment of contributions for working retirees in excess of what is needed for eligibility), not just those who are eligible for Medicare, in an effort to manage risk and ease plan administration.
- ❑ **Compliance with MSP rules.** The salaried administrator or TPA should keep a close eye on the hours being worked and how the plan is coordinating coverage on claims for participants with coverage under Medicare.
- ❑ **Shifting of claims risk.** Discuss with plan professionals how the shifting of retirees from Medicare to active coverage will affect the plans as well as stop-loss coverage.
- ❑ **Retirees who return to active status and retire once again.** Issues include:
 - **Banked hours:** If the plan provides for the use of banked hours before retiree premiums are due, any accumulated banked hours must be exhausted before Medicare begins or returns to paying primary. To accelerate this process, plans may consider applying the active rate for coverage rather than subsidized retiree rates against banked hours. They may also adjust hour bank balances when the contribution rate increases.
 - **Service requirements for retiree health coverage:** Plan documents should be clear about whether the return to work will reset any service requirements that apply to eligibility for retiree health coverage. Most commonly a short stint will not reset the clock, but plan trustees might think differently about longer periods of work, especially if the retiree continues to work after the expiration of a pension plan’s lifting of benefit suspension rules.

Additional Fiduciary and Plan Design Considerations

Navigating the MSP rules and deciding how to allocate the incoming contributions are not the only fiduciary considerations for welfare plan trustees. Unlike pension plan trustees, health plan trustees have wide latitude to set eligibility rules. Typically, eligi-

bility for retiree coverage is earned through service. These service-based rules often require the active participants to have a certain number of years of service or hours worked to qualify for retiree coverage. Many plans also require the active participant to have worked a certain number of hours in the years or months directly preceding the participant's retirement. These rules are meant to ensure that retired participants have a working history with the plan, as opposed to departing for the majority of their working years, only to resume working just before retirement, seeking to secure subsidized retiree coverage from the plan.

Health plan trustees should clarify how these service rules will apply to retirees who regain active status in order to avoid administrative confusion, unintended loss of coverage or both. In addition, many plans provide a host of other ancillary benefits such as death benefits, accidental death and disability (AD&D), and loss of time (or short-term disability) benefits. Trustees must address whether working retirees are entitled to some, all or none of these benefits when designing return-to-work rules.

Conclusion

As discussed previously, when employers and unions are faced with a temporary or even extended shortage of labor, retirees bring more than just extra pairs of steady hands. Their experience can be an invaluable resource, and the hours they will work will generate dollars not only for health plans but also pension, training, supplemental unemployment and other affiliated fringe benefit plans. But their return to work does not come without some legal and administrative considerations. These considerations, even the shifting of claims risk, are highly unlikely to outweigh the gains and the absolute need to ensure that jobs are properly staffed. However, they nonetheless must be considered in order to meet ERISA's fiduciary obligations and to ensure that the return-to-work process for retirees begins—and ends—smoothly for everyone involved.

bio



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Plan design governing returning retirees should be studied thoroughly and undertaken in close consultation with plan professionals. Any plan design changes should be documented in writing and clearly communicated to all plan participants to meet applicable notice obligations under ERISA and to ensure compliance with MSP rules.

Even if the plan has existing rules on this topic, revisiting them occasionally is a prudent and worthwhile exercise. It is also a good idea to periodically remind working retirees of these rules. Annual mailings, such as those sent during open enrollment, represent a good opportunity to reinforce that returning to work is not as simple as dusting off the tool belt from the garage.

Endnotes

1. The Medicare Secondary Payer rules apply in other situations in addition to when persons return to work, such as when a person is diagnosed with end-stage renal disease. This article, however, will discuss the application of these rules only to retirees coming back to work in covered employment.
2. 42 CFR 411.104(c).
3. 42 CFR 411.100.
4. 42 CFR 411.108(a)(1)-(11).
5. See 42 CFR 411.108(a)(1)-(11) for comprehensive list of prohibited actions.
6. 42 CFR 411.104(c)(1).
7. 42 CFR 411.104(b)(3).

Creative *Menopause B*

by | Lana M. Saal, Ed.D.



enefits: Supporting Women at Work



The economic costs of women in menopause include an estimated \$1.8 billion in lost time at work annually. Employers that offer benefits to address the health and wellness issues related to menopause may minimize these costs while improving women's health and demonstrating a culture of caring.

Many employers are leaning into building better employee benefits to target the dynamic needs of their changing workforce. One area receiving greater attention is benefits that address women's health across their life and health spans, which include health and wellness issues associated with menopause.

Looking at creative approaches for the health and well-being of female employees can demonstrate a culture of caring and compassion. It can also create feelings of belonging by women, especially those experiencing gendered ageism, and can be key to retaining and attracting new employees.

Menopause and Women in the Workplace

Economic Costs

Health issues across a woman's life span are unique. Nationwide, menopausal women account for almost 30% of the labor force (6,000 enter menopause daily).^{1,2} Three in four women experience menopausal symptoms, such as hot flashes and fatigue, and one in four suffers serious symptoms that may cause them to miss work or even lose their jobs.³

A woman spends an average of seven to ten years in menopause, with some estimates extending up to 14 years, which would equate to 20% of a woman's work span. Peri-

menopause (commonly referred to as menopause transition), which typically begins in a woman's late 30s to early 40s, adds eight to ten years to that total. Perimenopause brings visible (hot flashes, weight gain and hair loss) and invisible symptoms (emotional and sleep disruptions and negative feelings of self-worth). Together, menopause and perimenopause represent 34% of a woman's work span, helping to make the case for menopause benefits.

Menopausal women account for almost 30% of the labor force.

The economic costs of women in menopause include an estimated \$1.8 billion in lost time at work annually, along with an estimated \$26.6 billion in medical expenses paid by employers.⁴ Out-of-pocket costs (both direct and indirect) for employees are estimated to average \$2,100 annually in the U.S.⁵

Workplace Culture

Considering how many female employees are going through some phase of menopause, it may make sense to incorporate menopause benefits into organizational strategic planning to consider factors such as workplace culture and diversity in addition to the financial impact.

Providing education on the topic of menopause, including its impact and influence on employees and the workplace, can help to inspire a culture of awareness, acceptance and psychological safety, which is essential for positive mental health. Fostering a safe environment to address menopause helps future generations at work by creating higher levels of comfort for discussion and greater awareness of what they may experience individually.

Ensuring that women feel supported during this phase of life has far-reaching impacts on workplace culture. The average age of a woman entering menopause is 52, and the average age of a female CEO at hire is 54.^{6,7} Many women in this age range hold high-level management and leadership roles. About half of women going through menopause experience physical and psychological side effects, and they indicate that it negatively impacts their daily professional work lives and overall quality of life. This compels many to leave their positions and the workforce in general, which negatively affects their financial well-being and their careers.

takeaways

- Menopausal women account for almost 30% of the U.S. labor force. Three in four women experience menopausal symptoms, such as hot flashes and fatigue, and one in four suffers serious symptoms that may cause them to miss work or even lose their jobs.
- The economic costs of women in menopause include an estimated \$1.8 billion in lost time at work annually, along with an estimated \$26.6 billion in medical expenses paid by employers. Out-of-pocket costs (both direct and indirect) for employees are estimated to average \$2,100 annually in the U.S.
- A growing number of employers are offering benefits to address the health and wellness issues related to menopause.
- Employers should consider conducting surveys and working with employee groups as well as brokers and carriers to determine what benefits employees may want and what options are available.
- Benefits that employees in menopause may find valuable include enhanced employee assistance programs (EAPs) and behavioral health benefits, lifestyle spending accounts, reduced or \$0 copays for certain drugs or medical practitioners as well as workplace accommodations.

Repercussions for organizations include the loss of leaders, mentors and valued employees along with their history and expertise. Losing these employees also creates gaps in succession.

Getting Started With Menopause Benefits

In 2023, 15% of organizations with more than 500 employees offered menopause benefits, up from 4% in 2022.⁸ In addition, nearly two-thirds of women in the workplace indicate that they want menopause benefits.⁹

15% of organizations with more than 500 employees offered menopause benefits in 2023.

What may seem overwhelming can be approached through planning, collaboration and asking employees what they want and need to help make their work lives better. Following are some suggested steps for employers that want to get started on offering menopause benefits.

Conduct Surveys

Employers can gain insight into employee priorities and desires through anonymous surveys that ask a combination of quantitative and qualitative questions about their experiences and the impacts of menopause in the workplace. Leaders and decision makers may have their own ideas of new approaches and offerings, but these benefits must be relevant or they will go unused and may even be counterproductive.

Form Employee Groups

Surveys can ask for volunteers to create think tanks or employee resource groups (ERGs) focusing on menopause with representation from different backgrounds, cultures, ages and levels of employees across the entire organization, including male employees, to ensure inclusion and diversity. Nondistracting group space and time during working hours should be made available for discussion, brainstorming and suggestions to meet employees' needs.

Review Current Offerings and Policies

Reviewing all benefit offerings and policies for all employees will identify where gaps may exist. Approaching the cre-

learn more

Education

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The Next Stage: Level-Up by Adding Menopause Benefits as a Creative Solution to Positively Impact Your Organization On-Demand Webcast

Visit www.ifebp.org/webcasts for more details.

ation of menopause benefits is best accomplished through collaboration with representatives from talent acquisition, benefits, human resources and wellness departments as well as from leadership, management, and union or employee groups.

Employers can explore how menopause policies and procedures could mirror those used for other types of leave and time off, including fertility, maternity, paternity, adoption, child care, bereavement, flex time, remote or hybrid work options, and Family and Medical Leave Act (FMLA).

Work With Brokers and Carriers

Brokers and insurance carriers may be aware of creative ideas and approaches to benefits used by other clients. Employers should establish metrics to determine the impact and effect on claims, premiums or renewals. They also should make certain that added benefits are included within any requests for proposals (RFPs) and renewals with plans as well with any potential new vendors. The impact of menopause-related costs and claims should be reviewed annually.

Benefit Changes

Employers may find an opportunity to provide menopause-related benefits in the following areas. Suggested changes or action steps are included.

Prescription Drugs

Employers may want to consult with their pharmacy benefit managers (PBMs) to seek changes to prescription drug formularies or copays, including:

- Eliminating the copay on prescription female hormone support

Menopause Terms Defined

According to the National Institute on Aging:

Menopause is a point in time 12 months after a woman's last period.

The years leading up to that point, when women may have changes in their monthly cycles, hot flashes or other symptoms, are called the *menopausal transition* or *perimenopause*.

As a woman's body transitions to menopause, hormone levels may change randomly, causing menopause symptoms unexpectedly. During this transition, the ovaries make different amounts of the hormones estrogen and progesterone than usual.



- Adding coverage of bioidentical or compounded hormones
- Eliminating or reducing the copay for vasomotor symptom (VMS) medications that help relieve hot flashes or night sweats.

EAPs and Behavioral Health Benefits

Employee assistance programs (EAPs) and behavioral health benefits can play a role in helping employees navigate the psychosocial impacts of menopause.

- Expand the number of free counseling sessions to ten to 12 annually. This may help increase EAP utilization and demonstrate its value.
- Ask for specific menopause-related resources on the EAP portal.
- Include therapists who are subject matter experts (SMEs) in the psychosocial impacts and influences of menopause and can deliver counseling through in-person or telehealth visits.
- Purchase stress and support apps to provide additional mental and behavioral health benefits.
- Create access to or add women's interest groups as well as support groups (which may be virtual) to afford sharing opportunities and added levels of support.

Health Benefits

Health benefits changes can help women access improved menopause-related health care.

- Offer low or \$0 copays for physical therapy and specialists in pelvic floor, gyno-urinary and sex issues, as well as endocrinologists, since these specialists can positively treat and care for women going through perimenopause and menopause.
- Cover out-of-network providers that are North American Menopause Society (NAMS) Certified Menopause Practitioners and telehealth providers with a low or \$0 copay, especially in geographic areas where availability and access to specialists is limited or nonexistent.
- If offering fertility benefits, explore whether the vendor also offers menopause benefits as a component or can add it. Some vendors also offer menopause benefits as a standalone offering.

Wellness/Well-Being Programs

Targeted wellness initiatives can educate and engage all employees (not just those going through menopause) on a wide variety of whole-person health issues and approaches for well-care and self-care.

- Make sleep coaches available since lack of restorative sleep is one of the top health concerns that women in perimenopause and full menopause express as a top concern and challenge.
- Offer access to menopause subject matter health coaches telephonically, virtually or in person. Many insurance providers now include health coaches as part of covered services, and these coaches can often conduct on-site visits.
- Provide access to registered dietitians with expertise in the nutritional needs of women during this time, since changes in hormones often negatively impact a woman's weight.

Lifestyle Spending Accounts

Lifestyle spending accounts (LSAs) can reimburse employees for menopause-related services since well-being-related expenses are typically eligible expenses. Due to federal regulations, these items and services may not be eligible expenses for health savings accounts (HSAs) health reimbursement arrangements (HRAs), or flexible spending accounts (FSAs). LSAs can pay for fitness equipment, exer-

cise classes or gym memberships. Pilates, for example, has been shown to make marked improvements for those entering or in menopause.

Workplace Accommodations

Employers can make simple changes to make menopausal women more comfortable at work.

- Provide chilled bottled water or cold-water hydration stations throughout work locations.
- Create cooling stations or rooms or work areas with established lower temperatures and make fans available in offices and workstations for free to help relieve hot flashes.
- Offer free and easily accessible feminine hygiene products to help women cope with often marked and unexpected changes in their menstrual cycles.

Communications

Once a menopause benefits package has been created and approved, employers should carefully craft a solid communication plan promoting open dialogue and discussions around menopause along with all current and planned benefits. Some employers may wish to phase in the benefits over a one- to three-year period.

A multiphase communication plan can include the following.

- Sharing messages in an uplifting positive and informative approach
- Offering options for employees to provide ongoing feedback, such as an anonymous suggestion feature or email on the dedicated benefits web page. Ongoing feedback is critical for the greatest impact in evaluating what is effective, what is being accessed as well as the changing needs employees may have.
- Conducting short surveys to assess impact and relevance throughout the year as well as during open enrollment. Taking suggestions into consideration and sharing the results of surveys with employees is essential in creating a workplace that values the input from its employees.
- Seeking success stories by employees and sharing those through internal websites, which can positively impact the workplace culture of open discussion, impact and utilization of benefits and offerings

bio



Lana M. Saal, Ed.D., MCHES, CWP, CHWC, is the chief executive officer and founder of the VitHealthity Group, specializing in creative benefit solutions and biopsychosocial in-person and virtual programs for navigating through menopause. She has 25 years of expertise leading successful strategic solutions in benefits, health promotion, behavioral and mental health, nutrition, weight loss, fitness, stress management and tobacco cessation and is president of the board of directors for the National Wellness Institute. Saal can be reached at DrLanaSaal@Vithealthity.com.

Finally, as part of an ongoing overall strategy, employers should track measurables such as claims, lost time, productivity and satisfaction as well as share employee impact stories with leaders and employees.

Conclusion

Creating a workplace with less absenteeism, enhanced productivity and higher engagement is essential. Building and enhancing menopause benefits coverage can let employees know that they are valued and cared about throughout all ages and stages in their work life and beyond. It can also contribute to an environment and culture where every employee feels that they belong and can be their best. 🧠

Endnotes

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MOVING TO THE

Accreditation for Registered Apprentices

by | **Patrick Rome**

Accreditation can be advantageous for apprenticeship programs when applying for funding and recruiting apprentices. ERISA training trust funds should make sure to weigh the benefits against the challenges when deciding whether to pursue accreditation.

THE NEXT LEVEL:

Union Apprenticeship Programs



Registered apprenticeship programs (RAPs) already adhere to standards established by the U.S. Department of Labor (DOL). But some Employee Retirement Income Security Act (ERISA) training trust funds may want to consider taking an additional step to gain accreditation from an accrediting agency.

The time and administrative work required to become accredited can seem overwhelming, but the benefits to the fund and apprentices may be worth the effort.

This article will explain accreditation, identify the benefits and challenges of seeking accreditation, and describe the process.

What Is Accreditation?

To gain accreditation, organizations undergo a formal review by an accrediting agency. Accreditation provides an additional stamp of approval by signifying that postsecondary institutions, including apprenticeship training programs, meet an acceptable level of quality and engage in continuous improvement.

There are many forms of accreditation, but the most beneficial for ERISA/RAP institutions is likely through an institutional accrediting agency recognized by the U.S. Department of Education (DOE). Institutional accreditation considers the entire institution whereas programmatic accreditation typically accredits specific programming within the institution. Institutional accreditation is widely

viewed as a better fit for ERISA/RAP institutions because its standards consider organizational structure, finances, human resources, student services, facilities, technical infrastructure, media resources and strategic planning.

For more details on accreditation and access to lists of accrediting agencies:

www2.ed.gov/admins/finaid/accred/index.html



Accrediting organizations are typically formed into commissions with elected commissioners who apply DOE-approved standards to make accreditation decisions. Standards are reviewed annually for DOE updates. Changes in standards can also be proposed by member institutions to be reviewed by the agency standards review committee. These changes are approved by a vote of the membership or commission. Examples of standards can include that learning objectives meet industry needs, all instructors possess minimum educational credentials, learning resources are adequate, and facilities and technical infrastructure are sufficient for quality learning.

RAPs are known for having strong technical instruction in place to align with on-the-job learning. The DOL registered apprenticeship standards provide a great framework for individual programs but can lack overall school guidance toward quality and institutional improvement. For example, RAP standards typically do not require a mission statement or strategic plan, while institutional accreditation standards do. Accreditation standards measure outcomes by setting individual program benchmarks for program completion, employment placement and licensing pass rates.

The Pros of Pursuing Accreditation

Trustees have several considerations when making the decision to pursue accreditation. Following are some of the benefits of gaining accreditation.

Additional Sources of Funding

Many ERISA/RAP schools compete successfully for grant funding, but achieving accreditation can better position an institution to qualify for more funding opportunities. Several federal and state competitive grants require participation from an accredited education or training partner. While U.S.

takeaways

- Accreditation provides an additional stamp of approval that a registered apprenticeship program (RAP) has met an acceptable level of quality and engages in continuous improvement.
- The most beneficial form of accreditation for RAPs is likely through an institutional accrediting agency recognized by the U.S. Department of Education. Institutional accreditation standards consider organizational structure, finances, human resources, student services, facilities, technical infrastructure, media resources and strategic planning.
- The benefits of accreditation include the ability to access a variety of additional sources of funding, including grants and state education dollars. Accreditation also can be a draw for apprentices.
- Initial accreditation costs can run from \$30,000 to \$80,000, and annual dues typically range from \$3,000 to \$10,000. The process requires significant staff time.

Department of Labor (DOL) grants frequently target unaccredited ERISA/RAP schools, grants from DOE, foundations, community organizations and other sponsors require applicants to be accredited. Accredited ERISA/RAP schools now compete for grant funding with public and nonprofit schools.

Accredited ERISA/RAP schools also may qualify for state education funding. In recent years, accredited ERISA/RAP schools have found success in partnering with public high schools for dual or concurrent enrollment programs. These programs provide funding to ERISA/RAP schools when they offer pre-apprenticeship training for high school students either on the ERISA/RAP school campus or at the high school. Some of this shared funding can originate through federal Perkins grants or other sources. Dual or concurrent enrollment can provide credit toward a high school student's diploma as well as toward completion of an apprenticeship program. Schools should make sure to confirm what state rules require since they vary.

Foundations are often more receptive to considering accredited ERISA/RAP schools as beneficiaries. In particular, foundations that target workforce development or underserved populations may see accredited ERISA/RAP schools as able to fulfill the objectives of their giving mission. Foundations' funding decisions are grounded in trusting their beneficiaries, and accreditation helps build that trust.

Promotion of Continuous Quality Improvement

Accreditation standards encourage planning and require all program operational components to be addressed, which helps to ensure continuous improvement. Programs must conduct periodic reviews and have policies and procedures in place for the following areas.

- Strategic planning
- Facilities
- Technical infrastructure
- Health and safety
- Apprentice retention
- Learning outcomes
- Instruction
- Student experience
- Budgeting and forecasting

These are important accreditation standards that assure viability and resources in place for continuous improvement. They also are crucial elements of overall institutional quality,

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Online Resources

Top Trends in Apprenticeship Programs: 2024 Survey Report
Visit www.ifebp.org/apprenticeship for more information.

Apprenticeship Toolkit

Visit www.ifebp.org/resources/apprenticeships for more details.

and RAP standards don't necessarily address them in depth. Accreditation standards put the ERISA/RAP school on par with other postsecondary schools.

Enhanced Recruitment

Many ERISA/RAP schools have robust recruitment efforts in place, and the biggest draw to a RAP is the opportunity to be employed while going through the program and "earn while you learn." Accreditation may improve the ability of ERISA/RAP schools to compete with traditional colleges and universities for students. Marketing programs can tout that they meet the same institutional standards used by colleges and universities.

ERISA/RAP schools also can take their programming a step further by turning their apprenticeship programs into associate degree-level programs, which are important to many candidates. RAPs that add general studies courses can be formulated to create applied associate degrees. General studies in the areas of math, humanities, behavioral sciences, and natural and applied sciences can complement and enhance apprentices' technical learning and give them an extended career path.

Improved Employer Engagement and Learning Outcomes

Registered apprenticeship standards outline the responsibilities of joint apprenticeship and training committees (JATCs), which can sometimes get bogged down in administering these standards. In accredited programs, the administrative burden for policies and procedures is shifted to school administrators. When the program is accredited, JATCs can evolve into true advisory committees where the focus moves away from managing the apprentices to identifying essen-

tial knowledge, skills and competencies of the occupation. These evolved JATCs create an environment in which employers, subject matter experts and union representatives can collaborate to ensure that the curriculum is current with industry technology. The JATC can tailor learning outcomes to align with the employers' occupational needs.

Networking Benefits

One highly regarded accrediting agency has designed a unique "affinity" group for ERISA/RAP schools that enables members to work collaboratively on group concerns and propose standards changes. ERISA/RAP schools also have the opportunity to network with other types of postsecondary institutions including public, private, federal and Job Corps schools. Conferences and workshops provide a venue for schools to compare their operations and identify best practices at other schools to adopt.

Challenges of Accreditation

Costs

Depending on the size of the school, operational practices and documentation, total initial accreditation costs can run from \$30,000 to \$80,000. Annual dues vary depending on the size of the institution and accrediting agency, but they can range from roughly \$3,000 to \$10,000.

Costs include the following.

- **Accrediting agency charges:** Membership dues, application fees, stipends and travel costs for team visit evaluators who complete a virtual or on-site visit
- **Internal program costs:** Administrative and instructional staff

time to participate in the initial process, including time for developing new or reviewing existing policies; procedures, processes and plans adhering to accreditation standards. Staff time is also needed to prepare exhibits to document standards compliance to evaluators.

- **Consultants:** Consultants are available to guide schools through accreditation, or they can target specific areas where schools need help. Accrediting agencies provide guidance, but consultants can speed up the process and lighten the load for staff members.

Administration

The burdens of increased administrative work and additional documentation are part of accreditation. Schools must be vigilant in adhering to standards to ensure that they can provide evidence of compliance to accreditors at any point in time. Findings of noncompliance with standards are often related to a lack of documented evidence that a standard has been met.

Apprenticeship funds should conduct a cost-benefit analysis before pursuing accreditation. Future grant awards or other funding sources are not guaranteed, so schools should consider the multiyear investment costs of accreditation against this risk. Some schools have seen significant upsides to their accreditation investment with seven-figure returns. However, these returns have come after investing one to three years in establishing accreditation and setting up the infrastructure to pursue sources of funding.

Considerations for Pursuing Accreditation

- Access to additional sources of funding
- Promotion of continuous quality improvement
- Enhanced candidate recruitment
- Improved employer engagement and learning outcomes
- Administrative time
- Costs



Achieving and Maintaining Accreditation

Following are the steps included in a typical accreditation process.

Application

Some agencies require candidate applicants to attend a workshop before applying for candidate status. Depending on the accreditation agency, the school typically must:

- Have been in operation for at least one year
- Have graduates from at least one program
- Have a minimum enrollment level
- Demonstrate financial stability.

If the minimum criteria can be met, an application is submitted to the agency. Applications may also require additional information, including state approvals, enrollment and completion data, campuses, a mission statement, a strategic plan, a student handbook/school catalog, a certified financial audit report, staff rosters, an organization chart, organizational documents, a trustee roster, and operating policy and procedures.

Self-Study and Site Visit

The accreditation process requires a self-study report and a site visit by a team of evaluators. The entire school staff must participate in the development of the self-study, which compares the operation of the school to the accreditation standards and identifies challenges and solutions. The school also must prepare exhibits to provide documentation of its adherence to standards. The self-study is submitted in advance of the site visit. A team evaluation visit can last from two to four days. The visiting team completes an evaluation report that is reviewed with the institution and submitted to the accrediting agency. Any findings of noncompliance, suggestions and commendations are included in the evaluation report.

Accreditation Approval

The commission makes an accreditation decision after a review of the team report. The type and number of findings of noncompliance and commendations are very influential for the decision to approve and assign the number of years of accreditation. Many accrediting agencies have accreditation approval periods of two to six years. The commission may defer its decision until the school provides documentation that it has addressed any findings of noncompliance.

Maintaining Accreditation

Once an institution has been awarded a set number of approval years, it is required to continuously meet the accrediting agency's standards. Staff must understand those standards and monitor the operations of the school. Some accreditation agencies hold unannounced team visits to check on adherence to standards in between approval cycles. Along with reporting completion data annually, schools are expected to review those standards and attest to their institution's compliance.

Reaffirmation of Accreditation

Schools should start working on reaffirmation of accreditation approval 12 to 18 months before the end of the current

bio



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approval period. This includes developing another self-study report and hosting a site visit, which requires similar work and resources as the initial accreditation application. Consistently adhering to standards between cycles reduces the work required for reaffirmation.

Conclusion

ERISA apprenticeship fund trustees who decide to pursue accreditation should view the effort as a long-term strategic investment in the program. Trustees should be prepared to support the staff as they work through the process. Some of the outlined benefits can be recognized immediately, while others may take several years to materialize. Kirk Nooks, Ed.D., president and chief executive officer of the Council on Occupational Education (COE), offers valuable insight to leaders of ERISA/RAP schools that are considering accreditation: "The strategic decision to pursue the path of accreditation is a commitment to excellence. It requires an investment of resources, which will ultimately aid the organization to be among the best in terms of quality."

Accreditation requires a trust board's continued commitment, staff time and financial resources. Accreditation can seem overwhelming; however, the achievement of moving to the next level of quality and integrity and forming a culture of continuous improvement may be worth the venture. **h**

what's working

providing PPE
for mental health



Kevin Hendrickson
Business Manager,
Pipe Fitters Local Union 533,
Kansas City, Missouri



Patrick O'Hara
Vice President,
Instructor,
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Kansas City, Missouri



Curtis Ohlde
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by | **Kathy Bergstrom, CEBS**

As tradespeople in the construction industry, members of Pipe Fitters Local Union 533 in Kansas City, Missouri hear a lot about the importance of safety and personal protective equipment (PPE) to help them avoid injuries on the jobsite.

But the statistics for deaths by suicide and drug overdoses among construction workers show that paying attention to mental health is warranted in addition to addressing physical health. "We're not spending as much time working on mental health and changing attitudes about suicide and opioid overdoses as we are on PPE when it comes to contractors and our membership," said Curtis Ohlde, a leader of the recently established Local 533 peer mental health support program. "Those are things that we probably need to spend a little more time working on and letting our membership know about."

The union began setting up its mental health peer supporter program in 2022. Leaders say the program is helping to remove the stigma around mental health issues.

Seeing the Need, Fortuitous Connections

In 2021, Kevin Hendrickson, Local 533 business manager, and Luke Moylan, a union business agent and chairman of the health and welfare fund, met Nancy Spangler, Ph.D., who is a consultant for the American Psychiatric Association's Partnership for Workplace Mental Health, at the International Foundation's Annual Employee Benefits Conference in Denver, Colorado.

They told Spangler about their recent frustration in trying to help a struggling member find mental health resources. The union had also recently been hit with the untimely deaths of other members. "We just kept getting hammered with one thing after another," Hendrickson recalled. The union didn't know how to address these

issues, he admitted: "We work on pipes. We don't work on people's brains and emotions."

"We said we would really like to do something, to offer some help so that our members don't ever get to the point where they are considering hurting themselves or someone else," Hendrickson said. "We're a strong organization that takes care of each other."

Hendrickson and Spangler stayed in touch following the conference. Eventually she and a colleague, Robin Todd, visited the union hall for a listening session about mental health with executive board members, forepersons, journeypersons, apprentices and instructors.

Spangler and Todd, who owns a Kansas City-area mindfulness training company, recognized that members already looked out for each other, but they were missing one essential element—training.

Setting Up a Program

Training

Spangler and Todd conducted a mental health awareness class and mindfulness meditation training for all employees in the business office and the apprentice training center.

The first peer support training program was offered to training center instructors, and about 20 volunteered to participate. Hendrickson explained that the union chose to start with instructors because of their comfort with brainstorming and creating new programs.

The formal training included a one-day in-person immersion session and three virtual follow-up sessions. Training focused on mental health awareness, mindfulness, available mental health resources, and how to reach out and be an active listener. "The peer supporter's job is not to be a counselor," Hendrickson stressed. "The vol-

unteer's job is simply to be someone who's there to listen without casting judgment."

Peer training was also offered to second-year through fifth-year apprentices, and the union now has about two dozen volunteer peer supporters who are available to help any of the union's 1,900 members as well as their family members.

Training will eventually be offered to all members who are interested. "Our goal is to have a system where at least once a year anyone who's interested in getting this training to be a volunteer will have the ability to get the training," Hendrickson said.

Communication and Logistics

Local 533 decided to have the union operate the program rather than the health and welfare fund for ease of setup, Hendrickson said. Ohlde and Patrick O'Hara, an instructor and Local 533 vice president, volunteered to lead the program.

The union contracted with a call center to establish a dedicated phone number for the program. Depending on the caller's needs, the operator will connect them to a crisis line or directly to a peer supporter.

The peer support program has a button on the Local 533 website home page, and the union designed stickers and magnets with a QR code that sends members to the peer support website. Ohlde also recently promoted the program on the *Fitter Talk* podcast that he hosts, and peer supporters were available at the union's health fair.

Getting Started Is Half the Battle

"If nothing else, I think we're seeing that the membership as a whole feels more comfortable to talk about struggles that they may be having," Hendrickson said. "And the inverse

side of that is our members are more receptive to listening to someone else without being judgmental." A future step will be to get contractors involved in the peer support training.

The union continues to promote the program and has not gathered any statistics on contacts, but Ohlde and O'Hara have been contacted personally by members, and other peer supporters have reported interactions. In addition, some employers have reached out to peer supporters looking for help with members on the jobsite.

One initial hurdle the union experienced with the program was that the peer support page was only accessible to members who logged into the website, and only a fraction had set up log-in credentials. Now the peer support program is easily accessible without requiring a log-in.

Local 533 has the advantage of already being a tight-knit group, O'Hara commented. For the past year, the peer supporters have been working on developing a protocol that formalizes that peer support.

Ohlde and O'Hara also are realizing how much training is available and how much more there is to learn. "The further we get into it, when it comes to training, there are always more things that we can pick up and improve on," Ohlde noted. "There are more resources out there that we are constantly finding out about."

"My advice would be no matter how much money you spend, it's all worth it if you save one person, and no matter how challenging it may seem to try to get something started, keep asking different people for different ideas and sooner or later somebody's going to come up with the idea that's going to get you to the next step," Hendrickson said.





Member of the Moment

Ebony M. Simon

member profile

Serving

Trustee for the Amalgamated Transit Union (ATU) Local 770 Pension Fund in Mobile, Alabama. Appointed in 2018.

By Day

Fixed route operator for Transit Management of Mobile and financial/recording secretary for ATU Local 770



Biggest Reward as a Trustee

"Learning all the information that is available for trustees to take back to our plan members and letting them know what is going on with different pension plan and retirement information."

Biggest Challenge

"Trying to learn and take in the important information about retirement plans and benefit plans and to make sure that I'm giving out the correct information. Our fund's priorities right now include cybersecurity and protecting our plan benefits."

Favorite International Foundation Educational Program

"I have enjoyed all of the International Foundation programs because they all offer something different. I recently attended the Trustees Masters Program (TMP) at the 69th Annual Employee Benefits Conference in Boston, Massachusetts."



Advice for New Trustees

"Attend all the conferences that are offered by the International Foundation because the speakers are very knowledgeable and are willing to help in any way. Take in as much as you can."

First Job

Day-care worker



legal & legislative | reporter

42 Retirement Fee Judgment Affirmed in Favor of Plan Fiduciaries

The Second Circuit affirms the district court's judgment in a suit related to retirement plan fees in favor of the defendant plan fiduciaries.

44 Withdrawal Liability Case Dismissed for Failure to State Claim

A district court grants the defendants' motion to dismiss for failure to state a claim in a withdrawal liability action.

46 Plaintiff Not Due Late Payment Under Black Lung Law

A district court grants the defendants' motion for summary judgment and denies the plaintiff's cross-motion for summary judgment in a black lung benefits suit.

47 Court Weighs in on Social Security Leveling Option Benefits in Retirement Plan Dispute

A district court denies the parties' cross-motions for judgment as a matter of law in a dispute about retirement benefits.

49 Forgotten Top-Hat Plan Found Valid and Enforceable

A district court grants the plaintiff's motion for summary judgment and denies the defendant's motion for summary judgment.

51 Court Rules That Incentive Plan Is a Bonus Plan Not Subject to ERISA

A district court grants the defendants' motion to dismiss in a suit for benefits under a long-term incentive plan.

53 Plan Sponsor Owner Personally Liable to PBGC for Plan's Losses

A district court grants the plaintiff's motion for default judgment in a suit to recover losses suffered by a defined benefit plan.

54 Suit Against Former Plan Administrator Allowed to Continue

A district court denies the defendant plan administrator's motion to dismiss the plaintiff's claims for breach of fiduciary duties.

56 Employer's Request for Arbitration in Withdrawal Liability Dispute Denied

A district court denies the defendants' motion to compel arbitration and to stay proceedings.

57 Employer to Follow Collective Bargaining Agreement Audit Terms

A district court grants the plaintiff's motion for partial summary judgment to compel an audit in a contribution dispute.

59 Washington Update: New 2023 Form 5500 Series Reflects SECURE Act Changes

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Retirement Fee Judgment Affirmed in Favor of Plan Fiduciaries



FIDUCIARY DUTIES

The U.S. Court of Appeals for the Second Circuit affirms the district court's judgment in a suit related to retirement plan fees in favor of the defendant plan fiduciaries.

Background

The plaintiffs include a class of participants and beneficiaries of two 403(b) retirement plans sponsored by an employer. The defendants include the employer, the plan committee and plan advisors. The plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs brought this suit against the defendants, alleging breaches of their fiduciary duties under ERISA. The plaintiffs appeal from the entry of judgment in the defendants' favor. On appeal, the plaintiffs challenge (1) the dismissal of their claim that the defendant employer entered into a prohibited transaction pursuant to ERISA by paying the plans' recordkeepers unreasonable compensation, (2) the award of summary judgment against the plaintiffs for failure to show loss on their claim that the defendants breached their duty of prudence by failing to monitor and control recordkeeping costs, and (3) the award of summary judgment to the defendants on the plaintiffs' claims that the defendant employer breached its duty of prudence by failing to remove underperforming investment options and by offering higher cost retail share classes of mutual funds, rather than lower cost institutional shares.

Arguments and Discussion

First, the plaintiffs challenge the district court's dismissal of their allegation that the defendant employer violated ERISA by causing the plans to engage in prohibited transactions with their recordkeepers. ERISA restricts the set of transactions in which plan fiduciaries may engage, including (1) transactions tainted by a conflict of interest and thus highly susceptible to self-dealing, and (2) certain transactions involving a party in interest.

The plaintiffs argue that because the plan recordkeepers are service providers and hence parties in interest under ERISA, their furnishing of recordkeeping and administrative services to the plans is a prohibited transaction unless the defendant employer proves an exemption. The court finds that to plead a prohibited transaction violation under the relevant section of ERISA, a complaint must plausibly allege that the defendants have caused the plan to engage in a transaction that constitutes the furnishing of services between the plan and a party in interest where that transaction was unnecessary or involved unreasonable compensation. The court further finds that the relevant section of ERISA seeks to prohibit transactions involving the use of plan assets potentially harmful to the plan. Still, it falls on the plaintiffs, not the defendants, to allege in the first instance that the transactions were unnecessary or that the compensation was unreasonable.

In addition, the court finds that while the plaintiffs have alleged several procedural deficiencies regarding recordkeeping, their complaint does not plausibly allege that the compensation was unreasonable. Although the plaintiffs claim that the defendant employer failed to seek bids from other recordkeepers and neglected to monitor the amount of revenue sharing received by the plans' recordkeepers, such process-oriented allegations may well be sufficient to state a claim for a breach of the duty of prudence. Still, they cannot sustain

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

Decision: An appeal by a class of 403(b) plan participants and beneficiaries regarding recordkeeper compensation, plan fees and underperforming investment options failed to provide a basis for the fiduciary-breach claims.

a claim pursuant to the relevant section of ERISA regarding prohibited transactions.

The plaintiffs next argue that the plans paid substantially more than what the plaintiffs identified as a reasonable recordkeeping fee. Specifically, the plaintiffs argue that a reasonable recordkeeping fee for the plans would have been much lower in the aggregate when calculated using a flat fee based on a set dollar amount per participant. The plaintiffs argue that the plans paid many times more than the amount calculated by the plaintiffs. However, the court finds that this is insufficient to allege that the fees were higher than some theoretical alternative service. Whether fees are excessive is relative to the services rendered, and paying more for superior services is not unreasonable. The court also finds that the plaintiffs have failed to allege any facts about the relative quality of the recordkeeping services provided, and did not allege any facts that would suggest the fees were so disproportionately large that they could not have been the product of arm's-length bargaining.

The plaintiffs next argue that the district court erred in granting summary judgment to the defendants on the duty of prudence claim, premised on recordkeeping fees, and duty of prudence claims premised on the retention of underperforming investment options and on the failure to transition to lower cost institutional shares.

Furthermore, with respect to recordkeeping fees, the plaintiffs contend that the district court erred in awarding summary judgment to the defendant employer on the plaintiffs' claim that the defendant employer breached its duty of prudence by failing to monitor and control the recordkeeping fees. Specifically, the plaintiffs argue that the defendant employer acted imprudently by failing (1) to determine

whether the amount of revenue sharing with the recordkeepers was competitive or reasonable, (2) to solicit bids from competing recordkeepers on a flat fee or per participant basis, and (3) to engage in a reasoned decision-making process to determine whether the plans should move to a single recordkeeper.

The district court concluded that genuine issues of material fact remained with respect to whether the defendant employer breached the duty of prudence. Nevertheless, it granted summary judgment because the plaintiffs failed to establish that any breach resulted in loss. The court finds that because the plaintiffs failed to meet their burden as to loss, the court affirms the district court's decision.

Finally, the plaintiffs argue that the district court erred in awarding partial summary judgment to the defendant employer on the share-class claim and concluded that issues of material fact precluded summary judgment as to whether the defendant employer violated its fiduciary duty by failing to swap out the higher cost retail shares offered through the plans for lower cost, but otherwise identical, institutional shares. The court finds that a reasonable finder of fact could not conclude that the defendant employer could have forced, or should have tried harder to force, the recordkeeper to offer the plans the lower cost share funds at an earlier date, and because the plaintiffs failed to produce evidence of imprudence, the court affirms the district court's decision.

Accordingly, the court finds that none of the plaintiffs' contentions on appeal have a basis for reversal, so the court affirms the district court's judgment. 📌

Cunningham et al. v. Cornell University et al., No. 21-88 (Second Cir., November 14, 2023).

Withdrawal Liability Case Dismissed for Failure to State Claim



MULTIEMPLOYER PLANS

The U.S. District Court for the District of Delaware grants the defendants' motion to dismiss for failure to state a claim in a withdrawal liability action.

Background

The plaintiffs include a group of multiemployer pension plans and their present trustee. The defendants include multiple entities in the same corporate structure and under common control with other nonparty entities participating in the plans. The plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Certain nonparties were parties to collective bargaining agreements that required each to contribute to the plans on behalf of their employees. These nonparties decided to cease participating in the plans, resulting in their withdrawal. Later, the plaintiffs sent the nonparties a notice and demand setting forth a withdrawal liability assessment, as required under the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA). The nonparties requested a review of the assessment and subsequently initiated arbitration to contest the assessment. Later, the nonparties and the plaintiffs entered into a settlement agreement, agreeing to reduce the monthly payment amount of withdrawal liability.

Except for one entity, the defendants did not participate in the plans but were allegedly under common control with the nonparties when they withdrew from the plans. Specifically, some of the defendants directly or indirectly owned at least

80% of the total combined voting power of all classes of outstanding stock entitled to vote or at least 80% of the total value of outstanding shares of all classes of stock of the nonparty entities. Later, the nonparties petitioned for bankruptcy and ceased making monthly payments after filing the bankruptcy petition. The plaintiffs sent past due notices to the defendants, but the plaintiffs did not receive any payments.

During the bankruptcy proceeding, a dispute arose concerning various creditors' rights to the reserve account that one of the defendants used to satisfy the nonparties' obligations to the plaintiffs. The bank holding the reserve account sued one of the defendants, seeking a declaratory judgment to rule whose interest was superior to all other interests. Under the reached settlement agreement, the nonparties were permitted to use the reserve account to satisfy debts owed to creditors other than the plaintiffs, who were not parties to the settlement agreement.

Arguments and Discussion

The plaintiffs allege that the nonparties owe them the withdrawal liability payments under the relevant sections of MPPAA. Specifically, the plaintiffs argue that the defendants are jointly and severally liable for the nonparties' withdrawal liability because they are under common control with the nonparties at the time of their withdrawal from the plans.

In their motion to dismiss, the defendants argue that MPPAA does not provide a statutory cause of action for this type of action, and even if it did, the six-year statute of limitations or the doctrine of laches bars recovery. Under MPPAA, a party may bring a suit in federal district court for the following scenarios: (1) if no arbitration proceeding has been initiated, the plan sponsor may bring an action for collection after the statutory period for arbitration has passed; and (2) upon completion of the arbitration proceedings in fa-

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

Decision: Because the plaintiffs voluntarily dismissed the arbitration of a withdrawal liability dispute prior to the formal entrance of an award, they failed to state a viable claim under MPPAA, and their claim is dismissed.

vor of one of the parties, any party thereto may bring an action to enforce, vacate or modify the arbitrator's award. In other words, the action under MPPAA is available only in cases where the arbitration proceeding has not been initiated within the statutory period or has been completed. It is not available where the arbitration proceeding has been initiated but not completed, as the court notes is the case here.

The court finds that under the settlement agreement, both parties agreed to terminate the arbitration with prejudice, and the nonparties also agreed to waive their rights to restart arbitration proceedings in the future. Thus, the court finds that if the plaintiffs intended to preserve their right to enforce the settlement agreement terms, they could have requested the arbitrator to formally enter the award. If they did so, the plaintiffs could have brought this action under MPPAA, which provides a cause of action upon completion of the arbitration proceeding to enforce, vacate or modify the arbitrator's award. Instead, the plaintiffs voluntarily dismissed the arbitration with prejudice prior to any award. Consequently, the court finds that the award was never formally entered upon completion of the arbitration proceedings, so there is no award to enforce, vacate or modify under MPPAA.

The plaintiffs argue that another section of MPPAA generally authorizes civil actions to recover unpaid withdrawal liability from employers. Under MPPAA, a plan fiduciary adversely affected by any party's act or omission may bring an action for appropriate legal or equitable relief. The plaintiffs argue that the relevant section of MPPAA provides a statutory cause of action whenever the plan is adversely affected by the act or omission of any party under the withdrawal liability, and that is satisfied here because the nonparties defaulted by failing to make payments according to the settlement agreement, and that failure was not cured after receiving past due notices from the plaintiffs.

However, the court finds that under a precedential case law, the relevant section of MPPAA does not provide a cause of action for any adverse effect on multiemployer pension funds. The section answers only the question of standing: Who may sue for violating the obligations established by rel-

evant sections of MPPAA? In other words, the relevant section of MPPAA merely provides jurisdiction over this claim, but it does not define or create the claim itself.

The court further finds that if the relevant section of MPPAA provides an independent cause of action, such reading would render the dispute resolution scheme under other relevant sections of MPPAA largely superfluous. The court finds that such an interpretation would contradict fundamental principles of statutory interpretation. Under the plaintiffs' reading, whenever an employer defaults on a withdrawal liability payment, a pension fund could bring a suit in federal court and entirely bypass the arbitration scheme set up under relevant sections of MPPAA.

The plaintiffs argue that actions brought under the relevant section of MPPAA's "pay now, dispute later" scheme are examples of matters adjudicated by federal courts but fall outside the dispute resolution scheme. Under the "pay now, dispute later" scheme, the employer must pay according to the withdrawal liability schedule set forth by the pension plans, even when those payments become due during the pendency of arbitration. When an employer fails to make a payment during arbitration, a pension fund may bring an action in federal court to compel payment. The court finds that this narrow exception cannot stand for the general proposition that MPPAA authorizes a cause of action whenever an employer violates the relevant sections of MPPAA and harms a pension fund. Consequently, the court finds that even if the plaintiffs are correct that nonparties defaulted on their withdrawal liability payments and the plaintiffs were adversely affected, the relevant section of MPPAA does not provide an independent cause of action to collect the withdrawal liability.

Accordingly, because the plaintiffs have not stated any viable claim under the relevant sections of MPPAA, the court grants the defendants' motion to dismiss for failure to state a claim. 

Central States, Southeast & Southwest Areas Pension Fund et al. v. Laguna Dairy et al., No. 22-1135-TMH (D.Del., November 17, 2023).

Plaintiff Not Due Late Payment Under Black Lung Law



BENEFIT LITIGATION

The U.S. District Court for the Southern District of West Virginia grants the defendants' motion for summary judgment and denies the plaintiff's cross-motion for summary judgment in a black lung benefits suit.

Background

The plaintiff is an administrator of the estate of a deceased widow of a former coal miner. The defendants are the coal miner's former employers.

The coal miner worked for the defendants and contracted black lung disease. Prior to his death, he sought, but was ultimately denied, occupational disease benefits under the federal Black Lung Benefits Act. The widow filed for survivor's benefits under the Black Lung Benefits Act. Consequently, the Department of Labor (DOL) issued a decision and order awarding her back-payment benefits as well as a pension for the remainder of her lifetime. The defendants requested an administrative hearing respecting the DOL award decision; however, prior to the hearing, the widow died, and the plaintiff was appointed as the administrator of her estate. The plaintiff continued the pursuit of black lung benefits for the estate, and the administrative law judge issued a decision awarding back-payment benefits to the plaintiff. The defendants appealed the decision to the review board, which affirmed the administrative law judge's decision. Consequently, the DOL sent the defendants a computation letter showing the amounts to be paid to the plaintiff.

Court: U.S. District Court for the Southern District of West Virginia

Decision: A late penalty against the defendant employers is not warranted because they timely made all outstanding Black Lung Benefits Law payments to a decedent's estate.

Arguments and Discussion

The plaintiff claims that the defendants failed to pay the benefits in a timely manner. The defendants argue that the benefits did not become due until 30 days after the issuance of the computation letter. The plaintiff argues that the benefits owed became due 30 days after the issuance of the original order. Under the Black Lung Benefits Act, back-payment benefits are due 30 days after the following conditions are fulfilled: (1) an effective compensation order has been issued, and (2) the DOL computes the amount of benefits payable and provides notice to the parties. An order becomes effective after 30 days if no party timely requests revision of the proposed decision and order or a hearing. With respect to an order issued by an administrative law judge or the review board, the former becomes effective when it is filed, while the latter becomes effective when issued.

The plaintiff argues that the original order, which contained a computation of benefits, constitutes the effective order and computation triggering payment. The court finds that while a pending motion for reconsideration before an administrative law judge or a timely appeal of an administrative law judge's decision does not pause the due date of back-payment benefits absent a stay by the appropriate court, the order does not become effective and thus starts the 30-day clock after benefits have been computed if any party requests a hearing before the administrative law judge. Thus, the court finds that the plaintiff's contention that the original order constitutes an effective order is meritless. The court notes that the defendants timely paid all outstanding benefits to the estate, which discharged their legal obligations to the widow.

Accordingly, the court finds that the imposition of the late penalty under the Black Lung Benefits Act is unwarranted, so the court grants the defendants' motion for summary judgment. 🔄

Lester v. Consolidation Coal Co. et al., No. 5:22-cv-00324 (S.D.W.Va., November 17, 2023).

Court Weighs in on Social Security Leveling Option Benefits in Retirement Plan Dispute

The U.S. District Court for the Southern District of Ohio denies the parties' cross-motions for judgment as a matter of law in a dispute about retirement benefits.

Background

The plaintiff is a former employee of the employer and its predecessor, and a participant in a 401(k) plan and a pension plan, both sponsored by the employer. The defendant is the pension plan. The retirement and pension plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Until retirement, the plaintiff worked for the employer and its predecessor. When the employer acquired the predecessor, the plaintiff earned benefits under the pension and retirement plans. The benefit credits from the plaintiff's prior service were initially accrued under the retirement plan. Later, when the plaintiff's job classification changed, he began accruing benefit credits under the pension plan, while his benefit service accruals under the retirement plan ceased. Thus, at his retirement, the plaintiff had accrued benefits under both plans.

Under each plan, participants can elect a form of benefits before they retire. One option is a Social Security leveling option, which provides for a temporary period of higher payments designed to result in approximately a level of income when the participant's Social Security benefits are considered. In other words, if an individual retires before reaching Social Security retirement age, this option allows them to receive an increased monthly

benefit amount above what they would have otherwise been entitled to receive. When that individual begins drawing Social Security retirement benefits, the monthly benefit amount is reduced below what the participant would otherwise be entitled to receive.

Before the plaintiff retired, he elected the Social Security leveling option under both plans. Then, each plan began issuing the plaintiff monthly payments. When the plaintiff turned age 65, each plan reduced the monthly payments, assuming that Social Security benefits would cover the rest of the plaintiff's total monthly benefit. However, the Social Security benefit payments to the plaintiff were much lower than expected. Consequently, the plaintiff's total monthly benefit was significantly lower than before he began receiving the Social Security benefit payments. The plaintiff contacted the defendant, stating that the defendant made a mistake in calculating his leveling option. The defendant did not admit an error was made and provided the plaintiff with an alternative calculation to explain why the plaintiff was incorrect. The plaintiff sued the defendant, seeking to recover benefits due to him under the terms of the plans, to enforce his rights and clarify his rights to future benefits under the plans. The parties filed cross-motions for judgment as a matter of law.

Arguments and Discussion

The plaintiff alleges that the defendant miscalculated his benefits because it failed to consider that, although he was receiving his retirement from both plans, he only received one Social Security retirement check. Specifically, the plaintiff claims that each plan estimated that after the plaintiff turns age 65, his benefit under each plan would be reduced by the full amount of his Social Security retirement benefit. The plaintiff argues that under the terms of both plans, the defendant



RETIREMENT BENEFITS

Court: U.S. District Court for the Southern District of Ohio

Decision: A plan's calculation of the plaintiff's post-65 benefit amount is to be recalculated, making sure that it does not exceed the qualified joint and survivor annuity options.

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Social Security Leveling Option Benefits

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must correct his benefit and ensure that he is receiving benefits in the form he elected. The defendant responds that tax law does not permit the plaintiff's request. Specifically, the defendant argues that by offering a Social Security leveling option in the amount the plaintiff wants, the total amount would exceed the actuarial equivalent of qualified joint and survivor annuity benefit options, which is impermissible under the Internal Revenue Code.

The court finds that the evidence offered by the parties is not so overwhelming that a reasonable jury could not find for either party. In addition, the court finds that although the Internal Revenue Code prohibits any option being greater than the qualified joint and survivor annuity options, the most crucial factor to consider is the language of the plan as

known by the employees. Here, the plaintiff knew the language of the plans to support him in his retirement years, as leveled with his Social Security benefits. Therefore, the court finds that the plaintiff cannot be left with no remedy at all, so the defendant's calculation of the plaintiff's post-65 benefit amount is to be set aside and recalculated in a manner that prorates the plaintiff's Social Security benefit amount while making sure that the calculation does not exceed the qualified joint and survivor annuity options under the Internal Revenue Code and governing Treasury regulations.

Accordingly, the court finds that while the benefit amount should be recalculated, the evidence offered by the parties is not so overwhelming that the matter should be resolved at this stage. Hence, the court denies the parties' cross-motions for judgment as a matter of law. 🚫

Gragg v. UPS Pension Plan, No. 2:20-cv-05708-ALM-KAJ
(S.D. Ohio, November 14, 2023).

Forgotten Top-Hat Plan Found Valid and Enforceable

The U.S. District Court for the District of Arizona grants the plaintiff's motion for summary judgment and denies the defendant's motion for summary judgment in a top-hat plan dispute.

Background

The plaintiff is the wife of a deceased co-founder and former employee of the defendant corporation. The defendants include the decedent's corporation, a top-hat plan sponsored by the defendant corporation and the plan administrator. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Sometime prior to 1990, the decedent and his son co-founded the defendant corporation. In 1994, the decedent married the plaintiff and presented his son with a draft of the plan, which the decedent intended to provide for the plaintiff should he die before her. The plan promised monthly payments to the decedent upon his termination of employment or disability. Upon his death, the monthly payments would be paid to the plaintiff for the remainder of her life. The plan identified the defendant administrator as the plan's named fiduciary and administrator. The resolution of the board of directors of the defendant corporation to adopt the plan was only signed by the decedent and the son but not by the defendant administrator, who was the third director. However, soon after the plan was executed, the defendant administrator sent a compliance letter to the Department of Labor stating that the plan was in effect.

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

Decision: The plaintiff wife is entitled to benefits from her deceased husband's employer-sponsored top-hat plan because the plan was validly executed and remains enforceable.

According to the son, the plan's existence was later largely forgotten. It wasn't until around 2010 that the decedent began discussions with the son and an accountant and attorneys regarding how to arrange for payments to the plaintiff after his death. The decedent wanted the plaintiff to receive an even higher annual payment than was contemplated under the plan. During the discussions, the son objected to the idea of the plaintiff receiving any shares of the defendant corporation. Despite the son's objections, the decedent decided to transfer some of the stock of the defendant corporation to the plaintiff. According to the son, the decedent and the son verbally agreed that the plan was to be replaced by the agreement to transfer stock to the plaintiff, although the written agreement between the decedent, the plaintiff and the son did not mention the plan.

After the decedent's death, the defendant corporation and the plaintiff negotiated a stock purchase agreement and completed a transaction in which the defendant corporation purchased the plaintiff's stock. Shortly thereafter, the plaintiff's granddaughter discovered a copy of the plan in the plaintiff's home. The plaintiff sent a demand to the defendant corporation for benefits under the plan. The defendant corporation adopted the position that the plan did not exist and refused to pay.

Arguments and Discussion

The defendants do not contest the fact that the copy of the plan is an accurate duplicate of the original. However, the defendants argue that the court should not consider the copy of the plan the plaintiff's granddaughter found based on the principles of evidence admissibility and fairness. Specifically, the defendants argue that the plaintiff's lack of knowledge of how the copy of the plan was found means she cannot establish the context in which this copy was found. The defendants argue that the



TOP-HAT PLANS

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Top-Hat Plan Found Valid and Enforceable*continued from previous page*

copy might have been located in a file with canceled agreements or stored with other documents that indicate it was canceled. The court finds the defendants' argument incoherent and baseless, especially because the defendant corporation produced an identical copy of the plan during discovery.

The defendants next argue that the decedent and the son reached a verbal agreement to rescind the plan and replace it with the agreement to transfer some stock to the plaintiff, which is sufficient to make the plan inoperable. The plaintiff responds that this argument is based on the decedent's alleged statements, which are inadmissible hearsay because they are offered for their truth. The defendants argue that the decedent's statements qualify as admissible because they fall under exceptions to the hearsay rule. The court finds that the alleged statements do not fall under any exceptions to the hearsay rule, so the son's testimony regarding the decedent's alleged statements cannot be presented in admissible form or considered at summary judgment.

The defendants next argue that the plan is not enforceable because it was never correctly adopted by the defendant corporation. Consequently, the plan is not enforceable without authorization by all the board members, namely the defendant administrator. The defendants also argue that the decedent was a beneficiary of the plan and that his vote authorizing the plan was illegitimate because he had a personal interest at stake. The court finds that there is no genuine dispute of material fact that the defendant administrator knew of and approved the execution of the plan because he later sent a letter to the Department of Labor regarding the plan. The court found that this action was sufficient to ratify the adoption of the plan. The court also finds that the defendants cite no authority that the decedent's participation rendered the resolution adopting the plan ineffective. Furthermore, assuming the decedent should not have participated, the plan was still approved by the son and ratified by the defendant administrator, who was the remaining board director. Consequently, the court finds that the plan was effective when it was initially adopted.

The defendants next argue that even if the plan initially went into effect, it was later abandoned or replaced. Specifically, the defendants argue that because the decedent did not mention the plan for some years, the plan was abandoned. However, the court finds that the defendants cite no authority showing that the absence of discussions indicates a contract was abandoned. The court notes that a contract will remain in place even when it is not a hot topic of conversation. Therefore, there is no basis to conclude the plan was abandoned.

The defendants further argue that the plan was replaced by merging into the later agreement to transfer stock to the plaintiff. In particular, the defendants argue that the integration clause in the agreement establishes that the parties intended to replace the plan because both documents were created with the same intent to provide for the plaintiff upon the decedent's death. The court disagrees and finds neither document states it intended to provide for the plaintiff. The court also finds that because the attorneys and accountant involved in drafting the agreement stated that the plan was never mentioned to them, surrounding circumstances do not establish that both documents had a shared subject matter. As a result, the integration clause in the agreement to transfer stock does not impact the enforceability of the plan.

Finally, the defendants argue that even if the plan was not later abandoned or replaced, there was an oral agreement between the decedent and the son to rescind it. The court finds that while it may have been possible for the plan to have been terminated through an oral agreement, there is no evidence of such agreement. Additionally, the court finds that even if the decedent's statements were admissible, the alleged agreement between the decedent and the son to rescind the plan could not have rescinded the plan between the decedent and the defendant corporation. Consequently, the court finds that the plan remained in place without a valid agreement between the decedent and the defendant corporation to rescind the plan.

Accordingly, the court finds that the plan was validly executed and remains enforceable, so the court grants the plaintiff's motion for summary judgment and denies the defendant corporation's motion for summary judgment. 📌

Schmidt v. Employee Deferred Compensation Agreement Dtd. July 3, 2003, et al., No. 2:22-cv-01464-ROS (D.Ariz., November 9, 2023).

Court Rules That Incentive Plan Is a Bonus Plan Not Subject to ERISA

The U.S. District Court for the District of Colorado grants the defendants' motion to dismiss a suit for benefits under a long-term incentive plan as not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Background

The plaintiff is a former employee of the defendant employer and a former participant in an employee benefits plan, which is a long-term incentive plan. The defendants include the plaintiff's former employer, the former employer's parent (which is a fund organized by a Native American nation) and the administrative committee of the plan.

Under the terms of the plan, the defendant administrative committee maintains a bookkeeping account for each plan participant and, each year, may credit each participant's account in an amount equal to the annual bonus earned by the participant that year. After a few years of participation, participants receive a yearly distribution in an amount equal to a certain percentage of the participant's account balance. This percentage increases incrementally based on the participant's age or years of service. Shortly before the plaintiff became eligible for an increased yearly distribution, the defendant employer terminated her. The plaintiff claims that she was terminated based on false allegations against her and that the defendant employer fabricated a for-cause termination to avoid paying the plaintiff the increased plan distribution. The plaintiff sued the defendants under ERISA.

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

Decision: A former employee's claims that she was terminated so her employer could avoid an increased distribution from a bonus plan are dismissed because the plan is excluded from ERISA coverage.

Arguments and Discussion

The plaintiff argues that the plan is covered under ERISA because it is an employee benefit pension plan. In response, the defendants filed a motion to dismiss, arguing that the court lacks subject matter jurisdiction because the plan is a bonus program excluded from ERISA coverage, so there is no basis for federal jurisdiction. The defendants argue that the plan is a *bonus plan* because, by its express terms and operation, it rewards employees and incentivizes them to stay employed, and it is not intended to provide retirement income.

The plaintiff argues that ERISA governs the plan because its purpose is for participants to defer income. The plaintiff contends that the plan is not a bonus plan because its participants receive a separate, distinct annual bonus unrelated to the plan. The defendants' bonus policies never mention that the plan's credit is part of an employee's bonus. The plaintiff further argues that the plan lacks participant discretion and that participants' plan accounts accrue interest and earnings, similar to traditional retirement accounts. Therefore, the plaintiff argues that the plan falls within the definition of a pension plan and is covered by ERISA.

The court notes that in order to determine the nature of an employee benefits plan and whether it is subject to ERISA, it must look to the plan's express terms and the surrounding circumstances. A bonus plan is excluded from ERISA if payments do not provide retirement income but serve some other purpose, such as providing increased compensation. First, the court finds that the plan's text and the plan's name, Long Term Incentive Plan, point to the conclusion that its express purpose is to reward and retain eligible employees, which suggests that the plan is a bonus or incentive plan, not a pension or retirement plan.



INTERFERENCE

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Incentive Plan Is a Bonus Plan Not Subject to ERISA

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Second, the court finds that other terms in the plan support this conclusion. Under the plan, the defendant committee creates accounts for eligible employees and credits them an amount equal to the annual bonus earned by the employee that year. Then, after a few years of participation, the employee receives a distribution payment equal to part of their account balance. The court finds that while in-service distribution payments do not automatically render a benefit plan outside of ERISA's scope, the critical factor in determining whether a deferred compensation plan is an ERISA pension plan is whether the plan allows payments to be made to employees during active employment.

Here, the distribution amount increases with seniority, and the plan states that the participant must generally be employed by the defendant employer on the date the distribution payment is made to be eligible to receive the payment. The court finds that these terms incentivize employees to remain employed by the defendant employer to receive their next distribution payment and to receive higher payments. The court finds that such provisions weigh in favor of finding that the plan is a bonus or incentive plan and, therefore, outside the scope of ERISA.

Responding to the plaintiff's arguments, the court finds that the fact that other annual bonuses are available to the defendant employer's employees does not render the plan an ERISA plan. The court further finds that although the plan does not permit participants to choose the amount or timing of the distribution payments they receive, this fact alone makes the plan a retirement account rather than a bonus plan. Consequently, the court finds that the plan is a bonus plan.

The plaintiff also argues that the plan systematically defers payments to the termination of covered employment or beyond, which renders it subject to ERISA. The plaintiff claims

that although the plan generally requires participants to be active employees to be eligible to receive the payment under the plan, the plan permits participants to receive distribution payments even after their employment ends. The plaintiff claims that, in practice, more than half of all distributions under the plan were post-termination distributions, proving that the plan systematically defers payments to the termination of covered employment and beyond, making the plan subject to ERISA.

The defendants respond that the plan does not systematically defer payments to the termination of covered employment and beyond. Only a small group of employees received post-termination distributions, which were due to a reduction in force, death, disability and employees reaching a certain age prior to their separation from employment.

The court finds that most distribution payments made to the plan were made to participants during their employment, and not after termination. This is consistent with the plan's general requirement that to be eligible to receive a distribution payment, the participant must be employed by the defendant employer on the distribution date. The plan also contains a forfeiture provision requiring that if the defendant employer no longer employs a participant on the distribution date, absent certain exceptions, all amounts in the participant's account are forfeited. As a result, the court finds that any post-termination distributions are not a systematic deferral of payment to the termination of employment or beyond.

Accordingly, the court finds that the plan does not systematically defer payments to the employee's termination of employment and beyond, and therefore, the plan is excluded from ERISA coverage.

Consequently, the court grants the defendants' motion to dismiss for lack of subject matter jurisdiction. 🚫

Faris v. Southern Ute Indian Tribe et al., No. 1:23-cv-00245-NYW-STV (D.Colo., November 8, 2023).

Plan Sponsor Owner Personally Liable to PBGC for Plan's Losses

The U.S. District Court for the Southern District of New York grants the plaintiff's motion for default judgment in a suit to recover losses suffered by a defined benefit (DB) plan.

Background

The plaintiff is the Pension Benefit Guaranty Corporation (PBGC), which administers and enforces the nation's DB pension plan termination insurance program and can bring actions as a statutory trustee of DB plans. The defendant is a former trustee and beneficiary of a DB plan sponsored by a company wholly owned by the defendant. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The defendant made several withdrawals of plan assets and transferred those assets to the defendant's corporate account. Later, the defendant decided to terminate the plan. However, upon termination, the plan had insufficient assets to cover the total benefits owed to participants and beneficiaries. The plaintiff sued the defendant, alleging that he failed to uphold his fiduciary obligations under ERISA and engaged in prohibited transactions of the plan funds. The defendant did not file an answer, so having received a certificate of default from the clerk of the court, the plaintiff moved for default judgment against the defendant. To secure a default judgment for damages, the plaintiff must produce evidence sufficient to establish damages with reasonable certainty.

Court: U.S. District Court for the Southern District of New York

Decision: The defendant's transfer of pension plan assets to his corporate account is prohibited under ERISA, and he is liable to PBGC for all losses suffered by the plan.

Arguments and Discussion

The plaintiff alleges that, as a trustee, the defendant was a fiduciary of the plan and violated his statutory obligations by causing the plan to transfer assets to the defendant's corporate account. The plaintiff argues that the transfer was not to pay benefits or expenses of the plan and was not in the sole interest of the participants and beneficiaries. The court finds that such conduct constitutes a breach of the fiduciary duty of loyalty and the fiduciary duty of prudence under relevant sections of ERISA. Therefore, the defendant is personally liable to the plan for these losses.

The plaintiff further alleges that the defendant engaged in transactions that constitute a direct or indirect lending of money or transfer between the plan and a party in interest, which was the defendant-owned entity, acting as the plan administrator and the plan sponsor. The court finds that ERISA bars a fiduciary from dealing with plan assets in his own interest or for his own account, except under circumstances expressly permitted under ERISA.

The court finds that the defendant's transfer of plan assets to his corporate account without a qualifying ERISA exception violated the prohibited transactions section of ERISA; therefore, the defendant is personally liable to the plan for these losses. Further, the court finds that the defendant is liable for the breach of its co-fiduciary, the plan administrator, which was the defendant-owned entity. The defendant knowingly participated in an act or omission of his co-fiduciary, and he knew of his co-fiduciary's breach but took no reasonable efforts to remedy the breach.

Accordingly, the court finds that the defendant is personally liable under ERISA for all losses suffered by the plan and alleged by the plaintiff, so the court grants the plaintiff's motion for default judgment. 🚫

Pension Benefit Guaranty Corporation v. Galicia,
No. 1:23-cv-04633-ALC (S.D.N.Y., November 7, 2023).



FIDUCIARY DUTIES

Suit Against Former Plan Administrator Allowed to Continue



FIDUCIARY DUTIES

The U.S. District Court for the Western District of Washington denies the defendant plan administrator's motion to dismiss the plaintiff's claims for breach of fiduciary duties.

Background

The plaintiff is a board of trustees of a multiemployer retirement plan. The defendant is a former third-party administrator (TPA) of the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

In 2011, the plan and a third-party service provider entered a recordkeeping and administrative services agreement, including asset custody services. The service agreement provided how fees would be calculated and paid to the service provider and included a flat annual fee, revenue-sharing amounts and an asset-based fee. Although the service agreement referred to the revenue-sharing amounts and the asset-based fee as amounts payable to the service provider, the plaintiff claims that the understanding and practice was that the asset-based fee was designated solely to pay plan expenses. Therefore, the revenue-sharing amounts and the asset-based fee were to be paid to a separate reserve account and used to pay qualified plan expenses pursuant to written direction to the service provider.

When the service provider sold its recordkeeping business to the defendant, the service provider informed the plaintiff that except as stated otherwise in a consent to assign agreement, the fee structure would not change. Later, the service provider emailed the plan about updating the fee

schedule and changing the administrative procedures to combine the expense accounts for the move to the defendant. The service provider also informed the plan that the defendant preferred to credit the revenue-sharing amounts directly back to participant accounts rather than use them to offset plan expenses. If the revenue-sharing amount was paid back to the participants, there was no need to reference the reserve account in the consent to assign agreement. The plaintiff alleges that the service provider assured the plan that the proposed fee changes consisted solely of changes to the revenue sharing and that the fees payable to the service provider and to the defendant were not increasing.

The plaintiff further alleges that when the defendant took over the service provider's functions, the defendant's system immediately began to have significant problems, including failure to timely and correctly deposit contributions into participant accounts. Consequently, the plaintiff terminated the defendant's services. Later, the plaintiff discovered that the amount from the reserve account (which held the revenue-sharing and the asset-based fee amounts) that the defendant transferred to the plan's new custodial bank upon termination was significantly lower than the plaintiff had expected. The defendant responded that it used the reserve account to pay itself fees that the plan owed at termination. The plaintiff alleges that the defendant paid itself fees that are double the fees payable to the plaintiff's previous service provider.

Arguments and Discussion

The plaintiff contends that the defendant was an ERISA fiduciary and that it breached its fiduciary duties. Specifically, the plaintiff alleges that the defendant was an ERISA fiduciary because it used its control and discretion to withdraw fees from the plan's assets beyond any previously agreed amounts, without warning, and without submitting invoices showing or explaining the fees

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

Decision: A multiemployer retirement plan board of trustees sufficiently states a claim that the plan's former TPA breached its fiduciary duties when it charged incorrect fees.

billed. The defendant responds that it did not act as a fiduciary when taking the action subject to the complaint and that, as a result, the plaintiff fails to state a plausible claim for relief.

The court finds that under precedential case law, to state a claim for breach of fiduciary duty under ERISA, a plaintiff must allege that (1) the defendant was a fiduciary, (2) the defendant breached a fiduciary duty and (3) the plaintiff suffered damages. A party may be a named fiduciary or a functional fiduciary if it exercises any discretionary authority or control respecting the management of such plans or exercises any authority or control respecting the management or disposition of its assets. The central inquiry is whether the party acted as an ERISA fiduciary when taking the action subject to complaint.

The court finds that although under precedential case law, a service provider is not acting as a fiduciary when withdrawing precise, preset fees from the pooled accounts, where a plaintiff alleges that a defendant withdrew more than it was entitled to, may plausibly allege a fiduciary relationship. Therefore, the court finds that the plaintiff's allegations that the defendant had control over the plan assets and that it used its discretion to withdraw fees unilaterally, inconsistent with the understanding and practice involving fees, are sufficient to state a claim.

The plaintiff next claims that the defendant violated contractual duties under the service agreement by failing to (1) timely deposit contributions; (2) correctly deposit contributions into participant accounts; (3) when contributions were corrected, provide requested information regarding how the correction was made or funded; (4) attend quarterly meetings or provide any reporting; (5) provide timely or substan-

tive responses to the plaintiff's questions and concerns; (6) make accurate entries in participant online accounts; (7) make timely distributions; and (8) provide information necessary for the plaintiff to complete annual audits. The plaintiff further claims that due to the defendant's breach, the plaintiff incurred damages.

The defendant responds that the plaintiff fails to allege causation or damages plausibly and that the plaintiff's damages allegations are conclusory and insufficient to state a claim. Further, the defendant claims that the plaintiff (1) does not allege what inaccuracies caused harm to the plaintiff or that they remain uncorrected, and (2) does not identify how the defendant's responses were lacking and what information was lacking.

The court finds that the defendant's arguments about plausibility are inconsistent with the plaintiff's pleading obligations. The court finds that at the motion to dismiss stage of litigation, the plaintiff only needs to provide a short and plain statement of the claim showing that it is entitled to relief. Here, the court finds that the plaintiff not only cites the services agreement as the instrument creating duties for the defendant but also cites the specific duties that the plaintiff believes the defendant breached, thereby causing damages. The court disagrees with the defendant that any more precise accounting of damages is required at this stage.

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

Board of Trustees for the Alaska Carpenters Defined Contribution Trust Fund v. Principal Life Insurance, No. 2:22-cv-01337-JNW (W.D. Wash., November 3, 2023).

Employer's Request for Arbitration in Withdrawal Liability Dispute Denied



ARBITRATION

The U.S. District Court for the Eastern District of Louisiana denies the defendants' motion to compel arbitration and to stay proceedings in a withdrawal liability dispute.

Background

The plaintiffs include a multiemployer pension fund and its administrator. The defendants include a former participating employer in the plan and the members of the employer's controlled group. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The defendants effected a complete withdrawal from the plan, and the plaintiffs notified the defendants of the withdrawal assessment and demanded an initial withdrawal liability payment to be made. After the defendants verbally requested additional information, the plaintiffs provided a formal response, beginning a period for either party to initiate arbitration on the claim. When the time for the initial payment expired, the plaintiffs informed the defendant employer of its need to cure its defect, but no withdrawal liability payment was made. The defendants filed a complaint and filed for arbitration through the American Arbitration Association, but the filing was untimely by over a year.

Arguments and Discussion

The defendants argue that their arbitration filing was timely. Hence, the plaintiffs' suit and discovery are premature because applicable law requires that pension withdrawal liability issues be subject to arbitration. The defendants further

argue that the plaintiffs did not provide the defendant member of the employer's controlled group with a timely formal response, so the defendants had additional time to initiate arbitration. However, the court finds that even considering this alternative timeline, the defendants initiated arbitration past their statutorily defined deadlines.

The defendants also argue that they initiated arbitration at an earlier date because their email exchange and a telephone conference with the plaintiffs were sufficient evidence showing the action of initiating arbitration. Specifically, the defendants argue that their request for the plaintiffs to provide the defendants with a list of arbitrators is sufficient. The defendants further argue that nonprecedential case law, which dealt with an employer that was noticed with withdrawal liability but failed to comply with all the arbitration rules, supports their argument. The employer in the cited case claimed compliance with the parties' arbitration rules by sending a letter to the opposing party asking it to consider it as a demand for arbitration. The defendants argue that the court in the cited case did not counter the employer's assertion that the letter met the minimal requirements of an arbitration demand.

The court disagrees with the defendants and finds that the formality and clarity of the employer's letter in the cited case far outstrips the email correspondence produced by the defendants. While the employer in the cited case provided a demand for arbitration, the defendants here merely sought arbitrator recommendations. The defendants respond that they could seek only so much, with their initiation attempts constrained by the plan's language. The court finds that although the arbitration provisions in the plan are ambiguous, the court also finds that the plan mandates the withdrawing employer to follow the requirements of ERISA.

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

Decision: A withdrawing employer and members of its controlled group failed to timely request arbitration under ERISA, so a withdrawal liability dispute will continue in the district court.

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Employer to Follow Collective Bargaining Agreement Audit Terms

The U.S. District Court for the Eastern District of Michigan grants the plaintiff's motion for partial summary judgment to compel an audit in a contribution dispute between a multiemployer plan and a participating employer.

Background

The plaintiff is a board of trustees of a multiemployer plan. The defendant is a participating employer under the plan and a party to a collective bargaining agreement (CBA) with union employees who are the plan participants. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The CBA obligates the defendant to make periodic payments to the plaintiff for various employee benefit funds and to submit monthly reports detailing the amount of contributions the defendant is obligated to pay on a timely basis. The agreement also prohibits the defendant from subcontracting work covered by the agreement and provides that any such work performed through a subcontractor is subject to the terms and conditions of the agreement. Furthermore, the agreement provides for regular payroll audits and comprehensive audits of records and accounts that the plaintiff can order to ascertain whether the defendant has complied with the requirements of the CBA. Comprehensive audits include examination of check ledgers, disbursement records and bank accounts, which are more likely to disclose payments to persons or subcontractors in violation of the CBA.

The plaintiff claims that the defendant has been habitually late with contributions and that regular payroll audits have repeatedly disclosed contribution shortfalls. In addition, the plaintiff suspected that the defendant was performing some of its work through a subcontractor in violation of the CBA. Before filing the lawsuit, the plaintiff attempted to obtain the documents necessary for the audit, but the defendant objected to providing the plaintiff with most of the requested documents. After the plaintiff filed the suit, the defendant offered additional documents. However, the plaintiff still wants to compel the defendant to produce relevant bank records, certain checks that raise issues regarding subcontractor agreements, and a subpoena for a company owned by the family of the defendant's owner regarding certain subcontracting documents.

Arguments and Discussion

The defendant does not dispute the plaintiff's right to enforce the terms of the CBA and agrees that because the plaintiff is a third-party beneficiary of the CBA, it is entitled to enforce it. The defendant also does not dispute that under precedential case law, the right of enforcement under ERISA also includes the right to audit outlined in the CBA.

However, the defendant argues that it has already sufficiently complied with all proper requests pertaining to the audit and that the other documents requested are a mere "fishing expedition" and are not authorized by the CBA. The defendant also argues that because bank records were not included in the original document request for the audit, the plaintiff is precluded from later requesting them.

The court finds that the documents requested are not limited to those necessary to determine whether the defendant has conformed with the provisions of the CBA. The court finds that the defendant does



MULTIEMPLOYER PLANS

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

Decision: A multiemployer plan may issue a subpoena for the bank records of a defendant participating employer, and the employer must comply with an audit to determine whether additional payments are due.

continued on next page

Employer to Follow Bargaining Agreement

continued from previous page

not refute the plaintiff's position that bank records fall within the scope of documents permitted to be investigated during an audit under the terms of the CBA. Furthermore, the court finds that the defendant provides no authority for its argument that bank records not initially requested are precluded from being requested later. Additionally, the defendant does not refute the plaintiff's stated reason for needing the bank records: the defendant does not have a general ledger or a check register, so the plaintiff needs to verify certain of the defendant's explanations by examining the defendant's bank accounts.

The plaintiff also requests permission to issue subpoenas to a company owned by the family of the defendant's owner

for certain subcontracting documents and to obtain the defendant's bank records. The court finds that given the lack of any general ledger or check register and the ongoing difficulty in obtaining bank records from the defendant, the court grants both requests to issue the subpoenas.

Consequently, the court finds that the plaintiff is entitled to the defendant's relevant bank records. The plaintiff may issue a subpoena to a bank for the defendant's bank records and a subpoena to a company owned by the family of the defendant's owner, and accordingly, the court grants the plaintiff's motion for summary judgment and to compel an audit. 

Trustees of the Painters Union Deposit Fund v. G&T Commercial Coatings, Inc., No. 4:22-cv-12471-FKB-APP (E.D.Mich., November 1, 2023).

Arbitration Request Denied

continued from page 56

Under ERISA, matters associated with this withdrawal liability, such as whether a withdrawal has occurred and what the proper amount of liability is, are resolved through arbitration. Either the plan sponsor or the employer may initiate the arbitration proceeding. After the plan sponsor reviews questions from the employer about withdrawal liability and is provided a basis for its determinations, arbitration must be initiated within 60 days. If no arbitration proceeding is timely initiated, the amounts demanded by the plan sponsor become due on the schedule set forth by the plan sponsor.

The plan sponsor may bring an action in a state or federal court of competent jurisdiction for collection. Parties may agree to additional arbitration details, but the ERISA

initiation requirements otherwise bind. Further, a party that unilaterally initiates arbitration must supply the other party notice. When the employer is the initiator, the notice must include a statement that it disputes the plan sponsor's determination of its withdrawal liability and is initiating arbitration. The court finds that likely due to the harshness of the rule, little circuit case law has developed on the failure to initiate arbitration. However, under case law, any beyond-deadline arbitration demands are improper.

Accordingly, the court finds that having failed to initiate arbitration in a timely manner, the defendants cannot attempt to reset the clock through a strained textual reading of their agreement, so the court denies the defendants' motion to compel arbitration and stay proceedings. 

New Orleans Employers International Longshoremen's Association v. United Stevedoring of America, Inc., No. 2:22-cv-02566-ILRL-JVM (E.D.La., November 2, 2023).

Washington Update

New 2023 Form 5500 Series Reflects SECURE Act Changes

In November 2023, the Department of Labor's Employee Benefits Security Administration, the Internal Revenue Service and the Pension Benefit Guaranty Corporation released informational copies of the 2023 Form 5500, Form 5500-SF, Form 5500-EZ and Form 5558 along with their related schedules and instructions. Federal regulations require certain retirement and welfare benefit plans to use these forms to file an annual return/report regarding their financial condition, investments and operations.

The key changes for 2023 reflect the Internal Revenue Code and Employee Retirement Income Security Act (ERISA) amendments made by the SECURE Act and include the following:

- A new Schedule DCG for defined contribution group (DCG) reporting entities
- A new Schedule MEP for multiple employer pension (MEP) plans
- A revised small plan audit participant count method
- New breakout categories for administrative expenses added to Schedule H administrative expense transparency, which is filed by retirement plans and large funded welfare plans
- Schedule MB, regarding asset reporting for plans receiving special financial assistance
- Schedule R tax compliance questions and revisions to asset allocation reporting
- Schedule SB, targeting normal cost reporting clarifications.

The instructions have also been updated for the current maximum Department of Labor administrative penalty for Form 5500 filing failures

(\$2,586 per day), with a reminder to check the Department of Labor website for annual increases. Also, beginning January 1, 2024, Form 5558 can be electronically filed through EFAST2 or filed with the IRS using a paper Form 5558.

Along with the informational copies was a fact sheet describing the key changes for the 2023 Form 5500 and 5500-SF. Those key changes include:

- A consolidated Form 5500 reporting option for certain DCG reporting arrangements
- Improved reporting by MEPs, including pooled employer plans (PEPs)
- A change in the participant-counting methodology for determining eligibility for simplified reporting alternatives available to small plans
- A breakout of reporting of administrative expenses paid by the plan on a plan's financial statements
- Further improvements in financial and funding reporting by PBGC-covered defined benefit plans
- The addition of selected Internal Revenue Code compliance questions to improve tax oversight and compliance with tax-qualified retirement plans
- Technical and conforming changes as part of the annual rollover of forms and instructions.

The news release is available at www.dol.gov/newsroom/releases/ebsa/ebsa20231117, and the fact sheet is available at www.dol.gov/agencies/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/changes-for-the-2023-form-5500-and-form-5500-sf-annual-return-reports.



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- **Survey reports:** Dig into the latest International Foundation research and find benchmark data on trending topics.

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Visit www.ifebp.org/benefitsknowledgecenter to get started.



Coming Up

Benefit Communication and Technology Institute

July 15-16, Denver, Colorado

This conference provides the tools you need to develop a comprehensive benefits communications strategy in addition to the latest information on technological enhancements, social media, and new benefits legislation and regulations. Trustees, communications managers and others who have a role in communicating employee benefits to plan participants will come away with creative ideas and workable solutions to their communications challenges.

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plan | ahead

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- 22-23** Trustees Institute—Level II: Concepts in Practice
Las Vegas, Nevada
www.ifebp.org/trusteeslevel2
- 23** Trustees and Administrators Institutes—Preconference
Las Vegas, Nevada
- 24-26** Advanced Trustees and Administrators Institute
Las Vegas, Nevada
www.ifebp.org/trusteesadministrators
- 24-26** New Trustees Institute—Level I: Core Concepts
Las Vegas, Nevada
www.ifebp.org/newtrustees
- 24-26** Accounting and Auditing Institute for Employee Benefit Plans
Las Vegas, Nevada
Virtual option available
www.ifebp.org/accountants



July 2024

- 15-16** Benefit Communication and Technology Institute
Denver, Colorado
Virtual option available
www.ifebp.org/benefitcomm
- 22-24** Advanced Investments Management (Wharton)
San Francisco, California
www.ifebp.org/advinv

July 2024

- 22-24** CONNECT Global Employee Benefits and Workforce Strategies Summit
Chicago, Illinois
www.ifebp.org/CONNECT
- 23-25** Designing Curriculum to Close the Skills Gap
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www.ifebp.org/skills-gap
- 29-Aug 2** Certificate in Global Benefits Management
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- 29-Aug 2** Certificate Series
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- 30-Aug 2** Certificate of Achievement in Public Plan Policy (CAPPP®): Pensions and Health Parts I and II
Boston, Massachusetts
www.ifebp.org/CAPPP

August 2024

- 19-21** Certificate in Canadian Benefit Plans
Toronto, Ontario
www.ifebp.org/canadacert

September 2024

- 14-19** Certificate Series
Nashville, Tennessee
www.ifebp.org/certificate-series
- 15-18** 43rd Annual ISCEBS Employee Benefits Symposium
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www.ifebp.org/symposium

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- 9** Mental Health in the Workplace
Virtual Conference
- 14-15** Collection Procedures Institute
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[schedule subject to change]

benefit fringe

happy 50th birthday, ERISA

Nearly 50 years ago—on September 2, 1974—President Gerald Ford signed the Employee Retirement Income Security Act (ERISA) into law. The International Foundation has been providing education on this landmark legislation ever since.

That education includes *ERISA Insights: Voices From the Early Days*, a book edited by Steven E. Schanes, who was the first executive director of the Pension Benefit Guaranty Corporation (PBGC). The 2001 book features the perspectives of more than 50 people working in employee benefits and covers the origins of the law as well as its impact and predictions for the future.

Although the book was not intended to provide a history of ERISA, several contributors offered personal accounts of the law's journey to Ford's desk.

What Does ERISA Stand For?

Contributors joked that ERISA has been called many other less-than-complimentary names, including “Every Ridiculous Idea Since Adam” and the “Actuaries, Accountants and Attorneys Full Employment Act.”

Impact of Special Interests

“Drafting was mostly serious business. We worked hard and long to tighten up, or at least prevent too much loosening, on participation, vesting and funding rules. There were lots of lobbyists trying to pull us every which way. Often we were successful in resisting exceptions for special interests, but sometimes we were not,” wrote William Posner, who worked for the Internal Revenue Service in 1974. Posner later became PBGC deputy executive director and chief operating officer.

Facing a Deadline

ERISA passed and was signed into law in the summer that President Richard Nixon resigned. Steven J. Sacher, an attorney who worked for the Department of Labor (DOL) in 1974, wrote that intense pressure was put on the staff

writing the legislation to get the bill before the House before it was expected to take up impeachment proceedings. (It was assumed that Nixon would not resign.) “As the rest of the nation watched the Nixon administration lurch toward destruction, the ERISA drafting staff was sequestered in a basement room of the Cannon House Office Building,” Sacher remembered.

The Importance of Preemption

Although they were often at odds, “large corporations and multiemployer health and welfare plans both perceived the danger of state-by-state regulation of their plans. The House and Senate provisions were weak and the Conference Committee adopted a preemption provision that probably was the broadest ever enacted. I refer to it as the keystone to the enactment of ERISA,” wrote Rep. John N. Erlenborn, who is recognized as one of the “four fathers of ERISA.”

But . . . About That Language

William J. Kilberg, who was the DOL solicitor in 1974, recalled an interaction he had with Senator Jacob K. Javits, the principal author of ERISA, as he reviewed the draft language of the preemption provision stating that ERISA would preempt state laws that “relate to any employee benefit plan.”

Javits asked Kilberg for his opinion on the clause. “I’m not sure what it means,” Kilberg said he told Javits. “The senator stared at me over his reading glasses for a moment, then turned back to the table.”

About a quarter-century later, at the time of writing, Kilberg said he was preparing to argue an ERISA preemption case before the Supreme Court. “The Court has dealt with over 20 preemption cases since 1974, three in the 1996-1997 term alone. ERISA articulates many rules, but not always with clarity.”

A Sign of Unity

Russell J. Mueller, a former member of the House Pension Task Force, recalled that following Nixon’s resignation on August 8, 1974, Ford appealed to Congress to “present him with legislation that would bring Congress and the new president together in an act of national unity. Congress complied by voting 402 to 2 in the House and 85 to 0 in the Senate to approve the ERISA conference report.”



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SPEAKER

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Sunday, November 10, 2024

Jon Meacham

Presidential Historian and Pulitzer Prize-Winning Author



The AI-Powered Organization

Monday, November 11, 2024

Mike Walsh

Global Nomad, Futurist and
Best-Selling Author



Economic Update

Tuesday, November 12, 2024

Marci Rossell

Economic forecaster, Former
CNBC Chief Economist and
Co-Host of Squawk Box



Moneyball: The Art of Winning an Unfair Game

Wednesday, November 13, 2024

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VP of Baseball Operations for the
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