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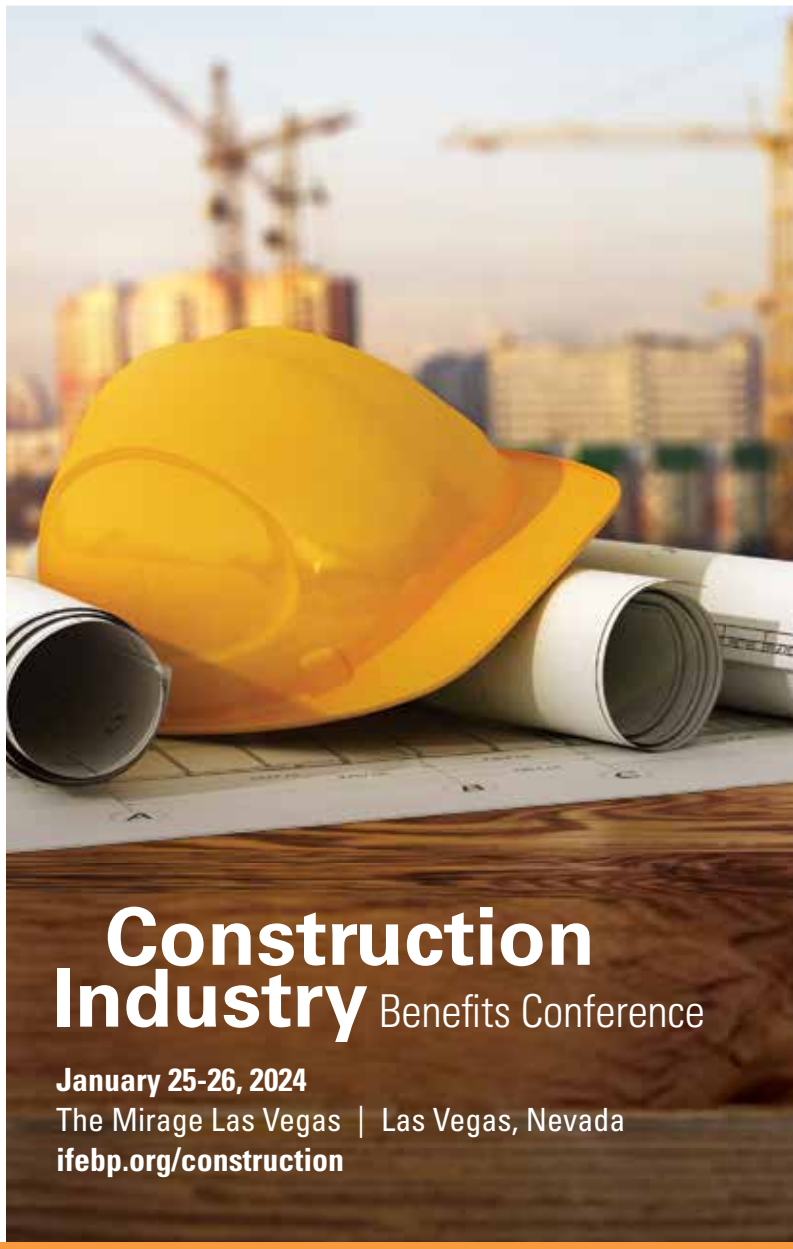

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We are trying to determine whether any benefits should be changed or adjusted for purposes of recruiting part-time employees. I'm curious what expansions others have offered to draw interest.

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contributors

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Ensuring that health plans are complying with the Mental Health Parity and Addiction Equity Act (MHPAEA) is a priority for the Departments of Labor, Health and Human Services, and Treasury, and the Departments recently issued new proposed rules to improve compliance. **Lisa M. Gomez**, assistant secretary of the DOL Employee Benefits Security Administration, discusses the new rules and overall progress on the issue of mental health parity.

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Health plan sponsors are facing additional scrutiny from federal regulators over cybersecurity and health information privacy and security practices. Attorneys **Katherine R. Kratcha** and **Sarah A. Sargent** provide an update on developments that have occurred in 2023. Kratcha is an attorney with Reinhart Boerner Van Deuren s.c. in Milwaukee, Wisconsin, and Sargent is a certified information privacy professional (CIPP)/U.S. and CIPP/E certified attorney at Godfrey & Kahn S.C., also in Milwaukee.

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Could the four-day workweek become commonplace as employers look for ways to attract workers and help them improve work-life balance? **Laura Earley, CEBS**, an account executive at IMA Financial Group in Denver, Colorado, discusses employer considerations for offering a four-day workweek. Earley is a member of the International Society of Certified Employee Benefit Specialists (ISCEBS) Governing Council.

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Hiring a professional trustee may be one solution that multiemployer benefit plan boards of trustees look to when they are struggling with trustee recruitment and retention, or need additional investment expertise, **Marc Rifkind** writes. Rifkind, who is of counsel at Murphy Anderson, PLLC, in Washington, D.C., reviews common scenarios in which professional trustees often serve but explains that the cost must be justified.

p 32

Multiemployer health funds may be unaware that some of their pre-65 retirees could be eligible for income and Medicare benefits through the Social Security Disability Insurance (SSDI) program. Authors **Kenneth B. Berry** and **Craig C. Horton** describe the benefits of SSDI as well as the application process. They review how receiving benefits from the program may help the financial position of retirees in addition to their health funds. Berry is director of labor and trust for SSDC Services Corp., and Horton is chairman of the company.

Terry Davidson, CEBS
Chief Executive Officer

What's New With HIPAA, Mental Health Parity and the Four-Day Workweek

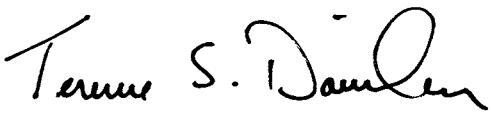
As an employee benefits practitioner, you need to stay on top of new developments—whether they're recent regulatory updates or workplace trends. This information is vital as you work to keep your plans compliant and competitive.

This issue of *Benefits Magazine* provides you with the newest information touching on both of those priorities. In the area of benefits-related regulations, attorneys Katherine R. Kratcha and Sarah A. Sargent discuss notable updates to the enforcement of the Health Insurance Portability and Accountability Act (HIPAA). In addition, Lisa M. Gomez, assistant secretary of the Employee Benefits Security Administration (EBSA), is featured in an interview discussing new proposed mental health parity rules.

Turning to new ideas, the concept of a 32-hour, four-day workweek has attracted a lot of attention of late. It hasn't caught on widely, as shown in the International Foundation's recent pulse survey, with just 5% of organizations giving it a try. However, an additional 14% of employers are considering implementation, and author Laura Earley, CEBS, points out that a growing number of workers may demand this new schedule in hopes of improving work-life balance.

This issue also includes information on the use of professional trustees for multiemployer benefit funds and the strategy of helping retired plan members apply for Social Security Disability Insurance benefits.

As 2023 comes to a close, I want to thank you for your ongoing commitment to education and better living through employee benefits. I wish you and your loved ones a happy holiday season.



Terry Davidson, CEBS
Chief Executive Officer

conversation | with Lisa M. Gomez

In late July, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury released new proposed rules to help improve compliance by health plan sponsors with the Mental Health Parity and Addiction Equity Act (MHPAEA). Plans have maintained that compliance with the law, which requires that mental health and substance use disorder benefits are offered in parity with medical/surgical benefits, has proved to be difficult, and the Departments have said that they will prioritize enforcement. The finalized rules are targeted to be released in 2024. Lisa M. Gomez, assistant secretary of the DOL Employee Benefits Security Administration (EBSA), discussed the proposed rules and the issue of mental health parity with Editor Kathy Bergstrom, CEBS.

Lisa M. Gomez
Assistant Secretary,
Department of Labor
Employee Benefits
Security Administration,
Washington, D.C.

What progress has been made in the area of mental health parity over the years?

I think there has been some progress in that there's more awareness of issues regarding the lack of parity between mental health and substance use disorder benefits and medical/surgical benefits.

Plans are making more serious efforts to look closely at their benefits and determine whether there are provisions—such as exclusions or medical management techniques—that may cause the plan to risk noncompliance. Often, these provisions may have been in the plan for a while, but people may not have paid attention to them, and they may be outdated since viewpoints toward mental health and substance use disorder care, as well as treatment options, have changed over the years.

That being said, progress has been slow.

What are the major elements of the proposed rules that plan sponsors should be aware of?

The proposed rules are looking to strengthen MHPAEA's protections. In putting together these proposed rules, we really leaned into both the feedback that we received from interested parties as well as the experience of DOL, Treasury and HHS in enforcing the law.

The proposed rules begin with a purpose provision, which makes it clear that MHPAEA requires that individuals should be able to access mental health and substance use disorder benefits in parity with and with no more restrictions than medical/surgical benefits. We start out with that overarching theme so that plans can be sure that they're always keeping that in mind in whatever they're doing.

The proposed rules have specific examples—many of which were based on real-life experiences of the Departments in doing enforcement—that make it clear that health plans and health insurance issuers can't use more restrictive medical management techniques like prior authorization and others for mental health and substance use disorder benefits.

Such restrictions are known as nonquantitative treatment limitations (NQTLs). MHPAEA requires plans to conduct a comparative analysis of their NQTLs to prove that their nonfinancial treatment limitations for mental health and substance use disorder benefits are no more restrictive than those for medical/surgical benefits and to provide them to DOL. However, our experience has been that audited plans are not prepared to submit complete comparative analyses and were missing information. The proposed rules provide more information on the content requirements for these analyses.

For example, the new rules set out examples regarding network adequacy standards for mental health and substance use disorder benefits to ensure that when people are seeking care, they can find in-network providers who are reasonably accessible from a time and distance standpoint. We're also looking at parity in factors to determine out-of-network reimbursement rates for mental health and substance use disorder providers. With all of that, we're trying to give plans a little bit more color for what they need to be thinking about when they are doing these NQTL analyses.

Another important aspect of the proposed rules is that they require health plans and health insurance issuers to look at outcomes data so that they can see whether their plans result in differences in access to mental health and substance use disorder benefits as compared with medical/surgical benefits. Even if it looks on paper like it would pass muster, if it doesn't in practice, then there's a problem. For example, on paper, it may look like a plan has an adequate number of in-network providers, but a plan may find out that in practice, some of these providers are actually not taking new patients or that there's a six-month wait.

In that same vein, the proposed regulations are specific in saying that plans and issuers have to conduct these comparative analyses so that they can measure the impact of the NQTLs that they have in their plan. They also should have the documentation and analyses ready to go prior to receiving requests from DOL or participants and beneficiaries.

It's putting more meat on the bones of what already exists so that we can make these protections more meaningful for participants and their families.

Why has the NQTL comparative analysis requirement been a difficult area of compliance for plans, and how will the new rules address that?

Part of the struggle is understanding how these rules play out in practice as well as what plan sponsors can be doing to dig more deeply into their plan documents and determine where there are areas of weakness.

Plans have also struggled with getting information from different service providers. Self-funded plans in particular rely heavily on the health care provider network organizations, pharmacy benefit managers, third-party administrators and other service providers. We're hoping that by providing more detail on the information that we need, plan sponsors will be able to use that to go to their service providers and be clear about what the Departments are looking for. We also hope that plan sponsors will come to us if they're experiencing these types of problems in getting information and cooperation so that we can try to help them work through it.

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DOL Guidance on Mental Health Parity: Proposed Rules for NQTL Comparative Analyses Word on Benefits® Blog

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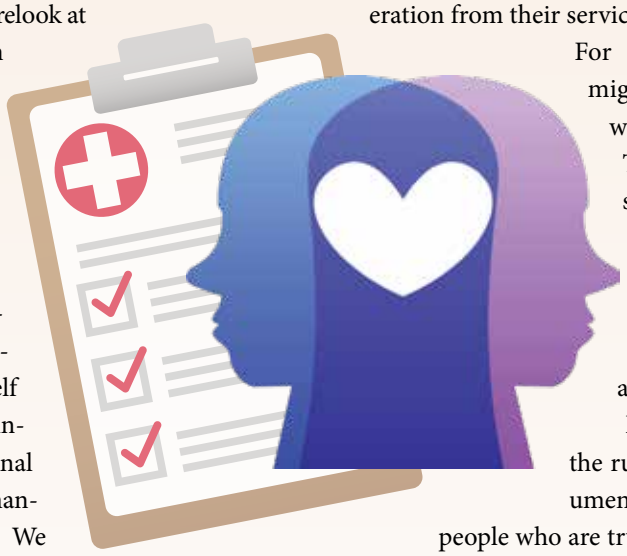
What are some mental health and substance use treatment areas that seem to have caused more problems with parity?

We have seen issues in the treatment of eating disorders. For example, some plans have exclusions for nutritional counseling for the treatment of eating disorders, but they will not have similar exclusions or limitations for people who have diabetes, gastrointestinal issues, cancer or other types of medical conditions. That relates to what I said previously that a lot of provisions are outdated and that plans may not have thought about or considered them for a while. There's no real reason for treating them differently.

Another type of treatment that we were seeing a lot of issues with relates to medication-assisted treatment for substance use disorders. A lot of plans may have had exclusions or restrictions on this type of treatment that are outdated and do not reflect current views on its effectiveness.

Many mental health and substance use disorder conditions have a stigma attached to them that is not attached to medical conditions. For example, it's just a reality that for many people, it's much more socially acceptable to say they need nutritional counseling because they have diabetes versus needing it because they have anorexia. We're trying to recognize and remove that stigma and identify when limitations that apply to those treatments are for no valid reason.

Applied behavioral analysis (ABA) for the treatment of autism is another example of something that years ago many plans either heavily restricted or excluded altogether. This type of therapy for autism requires a relook at what the basis for the exclusion or the restriction was and whether it's permitted.



These exclusions are another area where outside service providers and vendors play a role. Pharmacy benefit managers, third-party administrators and other service providers often have an off-the-shelf type of plan design that self-insured plans will use, or internal guidelines and other medical management tools that they apply. We are trying to work with those different providers to have them take another look and work with plans to remove these exclusions where it's appropriate and required by parity to do so.

What should plan sponsors be doing now in light of these new rules?

There are some pieces of coming into compliance with mental health parity that might be easier than others. Even if a plan hasn't yet gotten a request from DOL to provide a comparative analysis, it should be reviewing its compliance with the requirements of MHPAEA so that it can provide a comparative analysis when asked. Plans can start by looking at some basic things, like whether they have exclusions or network restrictions for mental health treatment that impose greater barriers than in the medical/surgical context—things that are kind of low-hanging fruit that can be addressed quickly. If they address those pieces, they can then focus on the pieces that are a little bit more challenging and that require collaboration to help achieve, including getting cooperation from their service providers.

For example, multiemployer plans might be able to build coalitions to work with the service providers. That way, the vendors understand that these plans want to pay attention to these issues sooner rather than later and not wait until they get a request for an NQTL analysis to address these issues.

Plans should focus on not only the rules and terms of their plan documents, but also the experience of people who are trying to access treatment for their mental health and substance use disorder needs. With the rise in mental health issues since the pandemic, there are lots of people who might not consider themselves to be in a crisis, but would like to see a therapist or other mental health provider before they get to that point. It should not be looked at any differently than someone who feels like their knee is starting to act up and wants to get physical therapy before it turns into full-blown arthritis.

Finally, when anybody—a plan sponsor, participant, beneficiary or fiduciary—thinks that a practice may violate MHPAEA, they can contact an EBSA Benefits Advisor. EBSA Benefits Advisors can help people sort out their rights and obligations with respect to benefit plans. Benefits Advisors take questions from the public and try to provide solutions, including informal resolution of disputes, for no charge. An EBSA Benefits Advisor can be reached by calling 1-866-444-EBSA (3272).

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Risks Abound
Safeguarding Health

by | **Katherine R. Kratcha** and **Sarah A. Sargent**

d:
Plan Data

The privacy and security of health information has become an area of increased focus for regulators following the Supreme Court ruling in *Dobbs* as well as several large data breaches. Health plan sponsors should take note and review their plans for compliance with HIPAA and other rules.

Over the last year, the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules (and the use of medical information in general) have received a significant amount of attention from both the public and regulators. In part, concerns around the privacy of medical information began to increase after the Supreme Court issued its decision to end the constitutional right to abortion in *Dobbs v. Jackson Women's Health Organization*.[1] In the wake of *Dobbs*, many consumers and government officials questioned how companies tracked and gathered online medical information. In addition to the privacy concerns raised post-*Dobbs*, several recent large vendor data breaches involving medical information have ensured that the security of medical information remains a top concern for organizations and regulators. This heat, light and attention on the privacy and security of medical information has resulted in notable updates in the past year to which every HIPAA-covered entity and plan sponsor should pay attention.

A Brief Privacy and Security Rules Overview

As a quick overview, the HIPAA Privacy and Security Rules establish standards for how covered entities, such as group health plans and their vendors, should handle protected health information (PHI).[2] For example, the Privacy Rule requires covered entities to provide privacy notices to individuals describing how the entity will use and disclose the individual's PHI and the individual's rights over their PHI.[3] The Privacy Rule also dictates when a covered entity or *business associate* (a vendor of the covered entity) may share PHI with third parties. If a covered entity shares PHI with a vendor, the vendor must commit to comply with the Privacy and Security Rules in a contract.[4] The Security Rule requires covered entities to maintain certain cybersecurity standards, such as maintaining written security policies and regularly reviewing security practices.[5] The Security Rule also dictates when covered entities must provide individuals with notices of a data breach.[6]

Enforcement and Consequences of Noncompliance

If an entity does not comply with the Privacy and Security Rules, it could face an investigation or enforcement action from the Department of Health and Human Services (HHS) Office for Civil Rights (OCR). Penalties include civil fines, criminal fines and criminal charges.[7]

OCR investigations typically start with a complaint or a breach report, although the agency also has the authority to initiate compliance reviews on its own. OCR investigates all reported breaches that involve 500 or more individuals[8] and also may investigate other reported breaches.

OCR generally prefers to enter into settlement agreements rather than impose civil penalties so that it may require the entity to prove its compliance during an oversight period—generally for three years—in addition to paying a settlement amount. Covered entities and business associates tend to prefer settling as well since the settlement amounts are lower than the civil money penalties that OCR would otherwise pursue and the entity is not usually required to admit a violation.

If OCR does impose civil penalties, the amounts range from $100 to $50,000 per violation.[9] Annual limits of approximately $25,000 to $1.5 million (adjusted annually for inflation) apply for all violations of the same requirement.[10] The penalties are tiered depending on culpability, ranging from whether the entity did not know and reasonably would not have known of the violation to whether the violation was due to willful neglect and not quickly corrected.

If a person knowingly discloses or obtains individually identifiable health information in violation of the HIPAA rules, OCR will refer the case to the Department of Justice for criminal investigation. As of July 31, 2023, OCR had made 1,862 such referrals.[11] Potential criminal penalties include a fine of up to $50,000, imprisonment of up to one year, or both, or higher fines and prison terms for offenses that involve false pretenses or the intent to sell, transfer or use PHI to gain an advantage or cause harm.[12]

In addition, the Department of Labor (DOL) has begun asking questions and requesting documents on health plans' cybersecurity and information security in investiga-

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tions. Many of these requests are consistent with DOL guidance from April 2021 regarding cybersecurity for plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). This guidance focused on retirement plans but is widely applicable to all ERISA plans.

takeaways

- Common online tracking technologies are, in the view of the Department of Health and Human Services Office for Civil Rights (OCR), causing breaches of the Health Insurance Portability and Accountability Act (HIPAA) and have resulted in lawsuits. Health plans and business associates need to know whether their websites or mobile apps use tracking technologies and what protective measures are needed.
- Large HIPAA breaches involving hacking and information technology (IT) incidents are becoming more common and affecting greater numbers of plans and individuals.
- The prevalence of large breaches is making careful contracting by plan sponsors all the more important to protect against a breach and minimize costs.
- Employee Retirement Income Security Act (ERISA) plan sponsors also should use the Department of Labor's April 2021 guidance to evaluate and bolster their plans' cybersecurity.

HHS Guidance on Online Tracking

One notable 2023 HIPAA update follows the fallout from OCR's December 2022 guidance on the "Use of Online Tracking Technologies by HIPAA Covered Entities and Business Associates."[13] The 2022 guidance clarified that the use of online tracking technologies, such as the Meta pixel, Google Analytics or other website cookies, could result in the impermissible sharing of PHI. For example, if a patient's IP address was shared with Google such that Google knew the patient logged into a specific hospital's patient portal or made an appointment with a provider, then such disclosure would be impermissible under the Privacy Rule unless the hospital had a business associate agreement with Google. Thus, the mere knowledge that an individual visited a particular website could be considered PHI. In addition, OCR stated that such impermissible disclosures may require covered entities to notify individuals of a data breach pursuant to the Security Rule.

After the guidance was issued, some health care providers did notify individuals of a data breach related to the use of online tracking technologies. Quickly after the guidance and notifications, a number of providers were also sued in class action lawsuits related to the impermissible sharing of PHI via online tracking technologies.[14] The lawsuits allege that the providers violated the Privacy Rule by sharing IP addresses with Meta, Google or other similar technology providers without a business associate agreement or any other basis that permitted such disclosures. While many of the original lawsuits are still pending, the number of tracking-related lawsuits continues to increase as plaintiffs' attorneys can easily see what tracking technologies a covered entity's website uses and can allege such disclosures are impermissible. Many entities are frustrated by the outcome of the OCR bulletin, and even the American Hospital Association called for OCR to finalize the amendment to the Privacy Rule and clarify that a mere IP address is not PHI.[15]

To avoid these lawsuits, plans should first investigate whether and how their websites or mobile applications use tracking technologies. An example would be a health plan web page that requires a user to log in and uses website analytics tools, such as Google Analytics, to track how a user navigates the website. If tracking technologies are used, then plans should have a detailed understanding of what information is being collected and shared with technology vendors. If PHI could be shared with a vendor, then a business associate agreement must be in place with the vendor. Plans should be cautious if they rely on vendors to manage tracking technologies since many vendors do not fully understand the latest OCR guidance on tracking technologies. Thus, plans should ensure that they receive correct information during these investigations and perform their own analysis of any technologies.

The Impacts of Large Vendor Data Breaches

A second notable 2023 update comes from the lessons learned from some of the large vendor data breaches that have impacted covered entities and plans recently. One such large vendor data breach was the 2020 ransomware attack against Blackbaud, Inc.—a software provider that hosted a large amount of PHI and donor information for thousands of organizations. After notifying its customers of the breach, Blackbaud faced an organized investigation by various state attorneys gener-

al and a number of lawsuits, including by its customer Trinity Health and its insurer Aspen American Insurance Company.[16] In the lawsuit, Trinity alleges that Blackbaud violated the parties' agreement, breached fiduciary duties, negligently misrepresented its security practices, and was negligent and grossly negligent. Trinity seeks reimbursement for the costs it incurred due to the data breach, such as costs related to mailing notices, providing credit monitoring and legal fees. However, the court held on May 31, 2023 that only the contract-related claims could move forward because there is no common law duty to protect the public from data breaches and Blackbaud did not owe any fiduciary duties to Trinity.[17] The lawsuit is ongoing, but the initial decision from the court shows the importance of fulsome privacy and security provisions in vendor contracts.

Without a well-negotiated contract, a plan could bear the brunt of costs related to a data breach and face an uphill (and expensive) battle in court to try to recover from the responsible vendor. For key vendors with access to PHI, whenever possible, plans should include the following in the contract (or business associate agreement).

- Specific security requirements above and beyond mere compliance with law
- Detailed reporting requirements related to data breaches
- An obligation to effectuate notice at the direction of the plan or to reimburse the plan for any incurred notification costs
- A provision requiring the vendor to indemnify the plan for any costs related to a data breach
- An exclusion from the limitation of liability for any costs related to data breaches

Notable Enforcement Updates

Sponsors of group health plans governed by ERISA also will need to keep two eyes out for enforcement, especially if they have been affected by a data breach. DOL has begun asking for information on health plans' cybersecurity posture in its investigations, and OCR is reorganizing to more effectively handle its caseload.

DOL appears to be using its cybersecurity guidance from April 2021 as a road map in investigations for health plans, similar to its approach with retirement plans. DOL guidance came in three publications: "Tips for Hiring a Service Provider," "Cybersecurity Program Best Practices" and "Online Security Tips." DOL began asking questions regarding retirement plans' cybersecurity in investigations soon after it published its guidance in 2021. Now, recent investigations indicate that the Department has gained enough experience with cybersecurity to start questioning fiduciaries of health plans as well. Although the DOL guidance generally is addressed to retirement plan sponsors and service providers, the fiduciary principles that it is based upon apply to all ERISA plans.

In addition to increased DOL enforcement, OCR hopes to increase enforcement of the HIPAA Privacy and Security Rules. OCR is reorganizing into three new divisions: Enforcement, Policy and Strategic Planning.[18] The agency is also renaming the Health Information Privacy Division to the Health Information Privacy, Data, and Cybersecurity Division (HIPDC) to better reflect its cybersecurity work. HIPDC will support the three new divisions in addressing health information privacy and cybersecurity.

The name of the new enforcement division makes its mission clear; OCR intends for the division to more effectively respond to complaints and drive greater enforcement of the law. OCR is trying to keep up with the continued growth in breaches and especially large breaches—those affecting 500 or more individuals. The 2023 OCR *Annual Report to Congress* regarding breaches of unsecured PHI offers the following statistics.[19]

- Between 2017 and 2021, the number of breaches affecting fewer than 500 individuals increased 5% and the number of breaches affecting 500 or more individuals rose 58%.
- Ninety-three of these reported large breaches in 2021 were from health plans, affecting over 3 million people.
- Hacking or information technology (IT) incidents accounted for 75% of large breach reports in 2021 and for 95% of the total number of people affected by large breaches of PHI.
- Hacking and IT incidents caused only 1% of smaller breaches (those affecting fewer than 500 individuals) reported in 2021 but affected a disproportionate number of individuals (24%) among those breaches.

In addition, OCR received more than 33,000 complaints in 2022 alleging HIPAA violations.[20]

The new policy division staff will work to increase implementation of HIPAA Privacy and Security Rules. Even though these rules are not new, many covered entities and business

associates could still use the help. In its most recent report to Congress, OCR identified a number of areas under the Security Rule that need improvement.[21] OCR thinks the following HIPAA Security Rule standards need better compliance.

- Conducting risk analyses, implementing security risk management measures and regularly reviewing system activity
- Implementing audit controls to catch and review malicious activity
- Allowing only those with proper access rights into systems containing electronic PHI

Conclusion

Covered entities and plan sponsors faced a variety of cybersecurity and privacy challenges this year, ranging from breach reporting and litigation over online tracking technologies to dealing with large breaches with service providers and facing additional scrutiny by federal agencies. Breaches and cyberthreats are not likely to decline in 2024. Plan sponsors should take the time to consider their plans' security and make any necessary changes for their protection.

Endnotes

1. 142 S. Ct. 2228 (2022).
2. Privacy Rule, 45 CFR Part 160 and Subparts A and E of Part 164; Security Rule, 45 CFR Part 160 and Part 164, Subparts A and C.
3. 45 CFR §164.520.
4. 45 CFR §164.502.
5. 45 CFR §164.308.
6. 45 CFR §164.404.
7. 42 USC §320d-6; 42 USC §1320d-5.
8. www.hhs.gov/sites/default/files/breach-report-to-congress-2021.pdf. Covered entities under HIPAA must notify affected individuals, the Secretary of the Department of Health and Human Services (HHS) and, in some cases, the media, after discovering a breach of unsecured protected health information (PHI) or learning of one by a business associate. If a breach involves 500 or more individuals (a "large breach"), the covered entity needs to notify HHS when it notifies the affected individuals—within 60 days of discovery—under 45 CFR § 164.408(b). Covered entities must report breaches involving fewer than 500 individuals to HHS annually by March 1 (February 29 in a leap year), under 45 CFR §164.408(c).
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bios

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WORKPLACE POLICY
PRODUCTIVITY
Practical Ap
of
Four-Day W
PERKS &
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FLEXIBILITY

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by | **Laura Earley, CEBS**

The implications of a four-day, 32-hour workweek extend beyond schedules to include human resources (HR) policies and procedures for vacation and sick time, payroll and more. What should employers and HR leaders consider before implementing a shorter workweek?

Change is hard. Acceptance of a new thing traditionally comes only after others have gone before us as guinea pigs. Whether it be the first airplane, built and tested by the Wright Brothers, or the first automobile, invented by Nicolas Joseph Cugnot, new things can be scary. Change can be scary.

Human resources (HR) professionals have had their fair share of change in the last decade, particularly around COVID regulations and remote work initiatives. Less critical programs like unlimited paid time off (PTO) or fully remote work didn't gain widespread acceptance until many brave employers implemented, tested, refined and perfected them.

COVID forced employers to implement remote work quicker than most other initiatives, and now they are facing the next new frontier: the four-day workweek. This worker-friendly perk has all the bells and whistles any worker could dream of: One fewer day of commuting (and less money spent on gas), one fewer stop at Starbucks, one fewer day getting dressed up for work and an even bigger impact for parents of young children . . . one fewer day for a child to be in child care (or not, for those parents who might relish the opportunity to take a day for themselves).

Proponents of the four-day workweek say it results in less stress for workers and helps them achieve better work-life balance. When it comes to the practical implementation, though, it's up to HR professionals to ensure that this new concept not only benefits employees but also that the work is still getting done, business doesn't suffer and customers are happy.

takeaways

- Some employers, including the city of Golden, Colorado police department, are experimenting with a four-day, 32-hour workweek that provides the same pay as a 40-hour workweek.
- More than nine in ten participants in a pilot program for a four-day workweek in the United Kingdom said they would continue with the shortened workweek.
- Organizations implementing such a concept should define productivity and output expectations as well as measure employee satisfaction and engagement to determine whether it is achieving the desired results for both the organization and employees.
- Setting a reduced work schedule impacts several human resources (HR) policies and procedures including payroll, vacation time accrual, overtime, holidays and more.

While offering a flexible work schedule can provide a significant boost for attraction and retention efforts, it's not as simple as closing up shop for one additional day per week. Employers have numerous challenges to consider. And just like remote work and unlimited PTO, a four-day workweek is not suitable for everyone.

If you're considering becoming one of the early adopters of this flexible perk, this article offers several considerations for ways to provide employees with an alternate schedule that meets both their needs and yours.

Compressed Schedule or Fewer Hours: What Does a Four-Day Workweek Look Like?

A four-day workweek isn't a new idea, but it's traditionally been applied in environments like call centers, manufacturing and police departments as well as with information technology (IT) staff, where shift work or after-hours work is common. These days, modified work schedules are becoming more widespread in other industries and work environments as they seek to attract and retain workers of all types.

Compressed Workweek

Many may think of a four-day workweek as one type of compressed workweek, with employees working four ten-hour days. In other versions of compressed workweeks, employees complete 80 hours in nine days, with every other Friday off. Another alternative could be three 12-hour shifts. Flexibility is key, and employers are getting creative in their attempts.

The Denver Police Department, for example, has used a four-day, ten-hour workweek for patrol officers for several years.[1] One officer explained to me that he gains 30 additional minutes of patrol time each week because he attends one fewer daily roll call on the four-day schedule, thereby increasing his productivity.

Thirty-Two-Hour Workweek

Some employers are boldly going where no employer has gone before: a four-day, 32-hour workweek for the same pay as a 40-hour workweek. You read that right . . . paying people 40 hours for 32 hours' worth of work. Where do I sign up?

When evaluating a 32-hour workweek, the expectation is that the same amount of work is completed in 32 hours as it was in 40 hours. Defining productivity and output ex-

pectations within teams is critical for success. The goal is to find ways to be more efficient, reduce distractions and be more "present" and productive in those 32 hours. Otherwise, organizations will simply see a 20% reduction in productivity.

Not only does the same amount of work need to be completed in a shorter period of time, but employee satisfaction needs to be evaluated to determine whether the schedule is working for employees. HR and senior leadership should set clear goals for satisfaction and engagement to ensure that employees aren't suffering from additional stress and deadlines because of the new 32-hour requirement. Employers should ask the following questions: Do employees have enough time to complete their work? Are their outcomes similar? Are their schedules being adjusted to reduce the number of meetings each week? Is productivity similar or better?

When approaching this 32-hour workweek concept, managers should understand that it might not fit everyone's lifestyle. Think of the unlimited PTO program, for example. While initial perceptions were that employees would run amok with time off and never be in the office, the reality was that use of PTO dropped among many employees. This new "take what you need" structure created a worse benefit for some because they only used what they felt they *needed* to use rather than what they *had available* to use under a prior arrangement.

Some employees may work 32 hours per week but end up feeling stressed and overworked during their workday due to managerial pressures, performance monitoring, requirements for increased productivity and the guilt over occasional social interactions. They may even spend their additional day off continuing to work, which defeats the purpose of the 32-hour workweek program.

Collaboration between management and employees to evaluate productivity requirements, establish guidelines for performance and determine areas for efficiency will be key to a successful reduced-hour workweek program.

How Prevalent Is a Four-Day Workweek?

About 5% of employers are offering a four-day workweek as a formal policy or on a case-by-case basis, a recent survey from the International Foundation of Employee Benefit Plans shows.

The *Four-Day Workweek: 2023 Pulse Survey* gathered responses from 376 corporate/single employer organizations across the United States. Key findings include the type of nontraditional schedules offered as well as the reasons for and challenges of implementing four-day workweek schedules.

In addition to the 5% that are currently offering a *four-day workweek* (defined as 32 required workhours spread over four days), 1% of employers are piloting a four-day workweek, and 14% are considering implementation. Nearly one-quarter (24%) of employers offer *compressed workweeks* (defined as working 40 hours in fewer than five days).

Employers cited the following reasons for implementing a four-day, 32-hour workweek:

- Request by employees—41%
- Retention strategy—36%
- Work-life balance/rethinking company culture—36%
- Recruitment strategy—27%.

Employers that do not offer four-day workweeks indicated the following reasons and concerns:

- Lack of interest by upper management—42%
- Difficulty implementing it organization-wide—38%
- Negative impact on business operations—36%
- Unsure if it would work with organization structure—36%
- Unable to support customer base—32%.

Visit www.ifebp.org/research for more details on the survey.

Employer Example: City of Golden, Colorado

The City of Golden, Colorado, a municipality in the Denver metropolitan area, is currently conducting a pilot program for a 32-hour workweek for its police department. Stated goals for the switch include improving employee retention and engagement, increasing employee well-being and "elevating efficiency in city operations."[2] Even the department's public-facing administra-

tive roles are part of this test program, not just police officers whose jobs can fit into shift work. "We are at the beginning of our journey, and we have more questions than answers. This is very eye-opening. We have to look at everything, and we have to challenge every assumption about the way we work," said Golden HR Director Kristen Meier, who is leading the charge of this pilot program, along with Police Chief Joe Harvey and City Manager Scott Vargo.

"A lot of workdays are chaotic. People put meetings on your calendar. They pop in and out of your office. Nobody works a solid eight hours. People take breaks, they take time to check in on social media. We have to define what productivity, output and success look like so we can track that and determine if we get the same productivity out of four days like we do out of five days," Meier said.

One would argue that an employer can't increase police productivity if officers patrol the streets one fewer day per week, but the city is figuring out ways to make the officers' jobs easier. "The goal is to ensure that the service to the city does not change," Meier said. "We are not closing on Fridays. We are still going to be available to the residents and to citizens the same times we always are. But we can work smarter, not harder."

One example is avoiding crossover between shifts. In a traditional environment, all officers starting their shift for the day would attend "roll call" to take on ongoing cases while the existing officers finished their time on the streets. In an updated environment, newly reporting officers start their shift on the streets, immediately relieving officers, while one team representative gets the update from the prior shift. That representative then passes the information along via radio or one-on-one direct communication to the impacted team or district. The city is going to try multiple versions of schedules and overlap to determine what works best to achieve an efficient and ideal handover between shifts.

The city is also considering technological solutions to assist officers with writing reports or perhaps adding employees to assist officers in writing those reports. In addition, the city is evaluating how other technology can augment and improve productivity so that the same amount of work can get done in less time.

Impact on Human Resources Policies and Procedures

Setting a reduced work schedule involves much more than cutting hours. It impacts payroll, vacation time accruals, overtime, holidays and more.

Payroll

From a payroll perspective, ensuring proper documentation of hours worked is critical. Employees who are exempt under the Fair Labor Standards Act (FLSA) are already paid for 40 hours regardless of actual hours worked. Their payroll challenges are less extensive than for hourly employees who need to track every hour worked.

Golden's pilot program will require officers to work anywhere between 32 and 40 hours for 40 hours' pay. From a payroll perspective, a standard week would be comprised of 32 hours worked and eight hours of administrative pay. However, if an officer is coming to the end of their shift, and they have a call that takes them over by two hours, they would be paid for 34 hours of work and receive six hours of administrative pay. The officers will receive overtime pay only when they go over 40 hours in a week.

Vacation and Sick Time

The next challenge comes when accruing vacation or sick time based on "hours worked." Employers that implement a four-day workweek have effectively given employees an additional 52 days off per year. An employee would argue, however, that those 52 days aren't taken all at once and that traditional vacation time or PTO is still necessary. One potential solution would be to move to an hours-worked vacation solution and accruing vacation time based on a 32-hour workweek, thus naturally prorating the vacation accrual.

It would make sense for an employer to evaluate its vacation accruals to determine whether the number of hours it offers is still adequate. Employers that were considering a revised vacation schedule to provide more time off might even consider a reduced workweek as part of their vacation strategy rather than adding traditional vacation or PTO hours.

Moving to a four-day workweek may result in a reduction in sick time absences. For example, employees may have fewer needs to take a "mental health day" and have one more day to recover from illness because of the additional day off per week. Employers should be prepared to track and evaluate sick time utilization to determine whether current accrual levels need to be adjusted.

Holidays

Holiday considerations are up next. If an employee has a four-day workweek and is normally scheduled to work when the employer is closed for an observed holiday, an employer has a few choices. That day could be treated as a paid holiday and the worker would work only three days that week. The employer could also shift an employee's schedule to have the holiday be their day off, expecting them to work the other four days that week, thus eliminating any holiday pay. Employers should spend time evaluating the holiday schedule as part of the entire time off program to ensure business needs are met while meeting employee needs.

Leaves of Absence, FLSA, ADA, FMLA, ACA

Employers should pay attention to compliance with state and local laws as well as federal laws, including the Americans with Disabilities Act (ADA), Family and Medical Leave Act (FMLA), Affordable Care Act and FLSA, among others. It is advised to consult with legal counsel to ensure that a reduced workweek would not cause employees any undue harm or result in discrimination. For example, if an employee's approved intermittent medical certification allows the employee to work four hours per day, could the employer require the employee to work four hours each day for five days per week? This scenario would result in 20 hours worked over five days while the remaining 12 unworked hours are covered by a disability program (or are unpaid), even though the employee only normally works four calendar days per week.

Schedule Considerations

Considering what day off to give is critical to the operation of a business. Most employees would like a traditional Friday through Sunday three-day weekend, but most employers aren't going to take a four-day workweek to mean that business stops completely for an additional day per week. Of course, not every employee has to be off on the same day, and a reduced workweek could mean employees are off on different days of the week to ensure that doors are still open to the public, that customer needs are still being met and that productivity doesn't change.

A flexible work schedule will look different for traditional Monday-through-Friday workers than it does for retail workers or round-the-clock operations like manufacturing, hospitals or police departments.

For 24/7 operations, a three-day weekend could mean three days off in the middle of the week. For Monday-through-Friday businesses, employers may need to consider split schedules to have the weekend off and then perhaps a third day in the middle of the week. Employers may also consider a rotating three-day weekend every few weeks to avoid one person always having a split shift.

An employer might consider whether there is one day per week when business is traditionally slower than others. City services might be extremely busy on the first day of a month or the last day of a month, and an employer may adjust the reduced workweek based on those needs.

bio

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Research Continues

If your organization is waiting on the sidelines, rest assured that researchers are continuing to gather data on the approach.

See the sidebar for results from a four-day workweek survey conducted in August 2023 by the International Foundation of Employee Benefit Plans.

In a massive pilot program in the United Kingdom, more than 60 organizations employing almost 3,000 workers signed up to be part of a six-month trial for a four-day workweek from June through December 2022. The indicative research being gathered by 4 Day Week Global, a nonprofit that advocates for a switch to a four-day workweek, reveals a general tenor of positive experiences alongside valuable lessons for some organizations that are striving to change decades of ingrained work cultures and systems.

According to a February 2023 report on the project, 92% of the pilot program participants surveyed about their experience said they would continue with a four-day workweek.[3] Companies rated the overall experience with the pilot project an 8.3 out of ten and rated business and productivity at 7.5 out of ten.

More than seven in ten (71%) participating employees responding to the survey reported reduced levels of burnout at the end of the trial. In addition, 39% of employees said they were less stressed and 43% said they felt an improvement in mental health.

"The four-day week trial so far has been extremely successful for us. Productivity has remained high, with an increase in wellness for the team, along with our business performing 44% better financially," Claire Daniels, CEO at Trio Media, one of the project participants, said in a press release from 4 Day Week Global.[4]

Is This Right for Your Organization?

Every industry has its own challenges when considering a four-day workweek. Whether your organization is a hospital, a police force, a school, a retail establishment or a traditional Monday-through-Friday office environment, a reduced schedule has far-reaching impacts. Whether you consider a traditional 4-10 schedule or take the bold step of a 4-8 schedule, the first question may be whether your organization can afford to keep doing things the way they've always been done, or whether the current employee-driven workforce will make that decision for you.

Endnotes

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quick look | large employer health care strategies

An increase in mental health issues—identified as the top prolonged impact on worker health and well-being from the COVID-19 pandemic—is a key area of focus for employers, according to a recent survey from the Business Group on Health. Employers responding to the *2024 Large Employer Health Care Strategy Survey* also weighed in on their approaches to improving health equity and containing health care costs. Following are some survey highlights.

Prolonged Impact of COVID-19 on Employee Health and Well-Being	Currently seeing impact	Anticipate impact	Do not anticipate impact	Don't know
Increased mental health issues	77%	16%	1%	5%
Increased access challenges due to medical care labor issues	30%	36%	19%	15%
More medical services due to worsening population health	28%	34%	22%	16%
Higher chronic condition management needs	21%	41%	21%	17%
Increased disability claims	21%	18%	35%	26%
Higher prevalence of late-stage cancers due to delayed screenings	18%	41%	19%	21%
Increased issues due to long COVID	10%	23%	39%	28%

TOP 7 Conditions Driving Health Care Costs

1. Cancer 86%
2. Musculoskeletal issues 75%
3. Cardiovascular conditions 30%
4. Diabetes 27%
5. Maternity 23%
6. Mental health 17%
7. Gastroenterology/digestive issues 12%

53% of employers offer on-site or near-site clinics.

Current Strategies for Addressing Health Equity

- 79% Work with employee resource groups to promote initiatives to targeted groups
- 58% Require health plan and navigation partners to maintain provider directories
- 47% Increase provider diversity through expanded networks
- 38% Seek employee input to identify disparities
- 36% Require health equity reporting from vendor/health plan partners
- 33% Offer dedicated care navigation for marginalized populations

Source: Business Group on Health. *2024 Large Employer Health Care Strategy Survey.*

Should You

r Fund Hire a Professional Trustee?

by | **Marc Rifkind**

Professional trustees can help multiemployer benefit funds with tasks including setting investment strategy, ensuring legal compliance and mediating conflicts among trustees. Funds that consider hiring a professional trustee must ensure that the cost is justified by the potential benefits to fund participants and beneficiaries.

As multiemployer funds face increasingly complex investment decisions and struggle with trustee recruitment and retention, some may consider hiring a professional trustee.

Professional trustees can be helpful in a variety of situations, including the process of determining fund investment strategy and ensuring compliance with applicable laws such as the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code. They can be hired to sit on the fund as an ongoing board member or be retained for specific tasks. This article will describe the situations in which a professional trustee's services may be beneficial to a fund and provide a framework to analyze whether the cost is justified.

When and Why Might a Multiemployer Fund Hire a Professional Trustee?

Often lost in the discussion of the administration of employee benefit funds is that they are tax-exempt businesses. But unlike the typical tax-exempt business with a similar asset value, they are run by individuals who are not selected for their experience with employee benefit funds and the aspects of their administration. In the case of multiemployer funds jointly administered by unions and the employers that employ their members, the trustees are appointed to serve by those entities.[1] Typically, serving in that capacity is not their primary job and, consequently, not one to which they can devote a large percentage of their time. Rather, they are often employed as officers of the union or by a participating employer or employer association.

Following are situations in which the services of a professional trustee might be helpful.

Trustee Investment Decisions

To discharge their fiduciary duties under ERISA, trustees invariably hire investment professionals to help them invest fund assets. Depending on their approach, trustees may interview and hire investment managers, decide how to allocate or reallocate assets among them, and choose whether and when to terminate them. Trustees who retain that scope of investment discretion typically retain an investment consultant to advise them on this process.

Alternatively, trustees may choose to hire an investment consultant who assumes the fiduciary responsibility to decide which investment managers to hire and fire and allocate assets among them. Under both structures, the trustees, in consultation with the investment consultant and the fund's actuary, determine an asset allocation strategy. Not surprisingly, since there's a lot of money to be made from the investment of plan assets, trustees—especially of those funds with significant asset values—are approached by salespeople with pitches to invest in schemes from commonplace transactions to unusual and creative strategies with various levels of risk. This creates a potential for a conflict of interest because a salesperson may have a personal relationship with one or more of the trustees.

Trustees must also keep track of and scrutinize the investment fee structure, a particular focus of the Department of Labor (DOL), which carefully assesses whether the fees are reasonable during audits. Paying excess fees is a major subject of 401(k) plan litigation because it decreases the value of the participants' individual investment accounts.

A qualified professional trustee may be able to assist trustees in making these types of investment decisions and help ensure that the trustees engage in prudent evaluation of investments. Accordingly, the professional trustee would need to be qualified to ask the probing questions necessary to understand the risk-and-return characteristics of an individual investment or investment scheme and know which other professionals (actuaries, attorneys and/or accountants) to involve in the process. The professional trustee also must be unbiased, knowledgeable about similar investment alternatives, and able to spot red flags and act accordingly. The

takeaways

- Multiemployer benefit funds seeking expertise in particular matters, including investment strategy and compliance, may consider hiring a professional trustee.
- Professional trustees also can help funds avoid prohibited transactions, avoid deadlocks and resulting arbitration, and mediate ongoing disputes. Professional trustees may be helpful tool for funds that have difficulty finding management trustees.
- Trustees will need to evaluate whether the cost of retaining a professional trustee is justified by the potential benefits to the fund and its participants and beneficiaries.
- Professional trustees are often experienced employee benefits attorneys, former fund administrators, longtime trustees or investment professionals.

professional trustee should be able to guide the board on what additional information it needs from the investment company to properly evaluate the proposed investments and the credentials of those assigned to manage the investments.

Compliance With ERISA Fiduciary Rules

Multiemployer fund trustees wear two hats: their employer or union hat and their fiduciary hat. But it can be difficult for trustees to remove their union or employer hat and don their fiduciary one to make decisions solely in the interests of participants and beneficiaries as the fiduciary rules require. Doing so requires an ability to distinguish between settlor functions—which are not fiduciary conduct unless the fund's governing documents define it as such[2]— and plan administration which, with some exceptions, is a fiduciary function.

Settlor functions include plan-establishment decisions such as drafting the original plan document and trust agreement and other governing documents, and plan design includes amendments to those documents. By contrast, plan administration includes all other day-to-day actions necessary to run the plan.

This is a particularly fraught area because trustees may not, without expert guidance, have the knowledge to distinguish between settlor functions and plan administration. This knowledge is critical to compliance with fiduciary obligations because, under ERISA, multiemployer fund trustees typically are both the "settlors" of the trust and the trustees under the terms of the applicable trust.[3] Without expert guidance, trustees may not realize that an action is fiduciary in nature and fail to recuse themselves from the consideration of a motion when they have a conflict of interest, as ERISA requires.

A qualified professional trustee is well-versed in the fiduciary rules and is able to recognize a potential fiduciary breach and know how to avoid it. In that case, the professional trustee could ensure that the board engages in the appropriate procedural prudence. Conducting the appropriate decision-making process when plan assets are involved is the touchstone of fiduciary compliance under ERISA. In situations where there is resistance to following fund counsel's advice, the professional trustee can help the other trustees understand the importance and potential consequences of refusing to follow counsel's recommendations. Inexperienced trustees may question advice that appears to be too conservative, such as when fund counsel advises against costly expenditures associated with fund meetings (e.g., first-class flights, holding meetings in foreign locations, etc.).

Avoiding Prohibited Transactions

Another difficult area for multiemployer fund trustees to navigate is compliance with ERISA prohibited transaction rules. One section of ERISA broadly prohibits certain types of transactions,[4] and a subsequent section exempts transactions that meet specific requirements.[5] ERISA defines *prohibited transactions* broadly to include transactions between a fund and a person or company that involve a potential for conflicts of interest. For example, using fund assets to benefit a trustee is generally a prohibited transaction.

Determining when a prohibited transaction may occur is tricky since the conflict and benefit bestowed on the person or company often are not readily apparent. For example, in one case, a trustee invested fund assets in fine art and hung the art in his home. Although the investment was extremely profitable for the fund, the trustee engaged in a prohibited transaction because he derived a benefit by displaying the art in his home. An experienced professional trustee may be more familiar with these rules and more likely to flag a prohibited transaction than less experienced trustees or even fund counsel. However, if the trustees are confident that their professionals have the necessary experience and training to identify such situations, they may not need to incur the cost of hiring a professional trustee solely for this reason.

Avoiding Deadlocks and Resulting Arbitrations

A professional trustee may be appointed by the union or the employer as one of the trustees allotted to them under the applicable trust agreement, but the parties could also jointly select a professional trustee as a neutral trustee to break deadlock votes. This arrangement is permissible under the Taft-Hartley Act since it specifically references the possibility that a plan could have a neutral trustee who could break deadlocks.[6] A board may be more confident in the decisions of a neutral trustee, who has experience with the fund and is a known and trusted advisor, than the decisions of an arbitrator, who is an unfamiliar third party. Resorting to arbitration to resolve deadlocks often delays decision making and is costly to labor and management, which split the cost. Another disadvantage of arbitration is that it engenders conflict

among parties who are tasked with working cooperatively for the benefit of participants. Resolution of deadlocks may not be a concern for board members on funds that have no history of deadlocks but could be a boon to boards that are often at loggerheads.

Mediating Disputes on an Ongoing Basis

In circumstances where management and union trustees frequently disagree on how to administer the fund, the board may benefit greatly from having a neutral trustee who can use their expertise to mediate disputes between them and find common ground.

Serving as a Management Trustee

Because of the risk, responsibilities and time commitment associated with serving as a trustee, funds often have difficulty finding management trustees. In such cases, management could address those obstacles by appointing a professional trustee to serve in that capacity.

Ad Hoc Services

Fund trustees may choose to hire a professional trustee on an ad-hoc basis for specific situations or hire a professional trustee or establish an ongoing relationship for a specific time period.

Will Your Fund(s) Benefit From Having a Professional Trustee?

Trustees will need to evaluate whether the cost of retaining a professional trustee is justified by the potential benefits to the fund and its participants and beneficiaries.

In the case of investments, that will partly depend on the on the nonprofessional trustees' level of investment experience, their ability to make impartial decisions, the amount of assets under management as well as the categories of the fund's investments and the types of new investments under consideration. For example, a fund with a conservative, vanilla portfolio (e.g., stocks and bonds) may have less need for a professional trustee than one with a more aggressive or esoteric portfolio.

Professional trustees may charge on an hourly basis, a monthly or annual retainer, or a project-by-project basis. Regardless of the payment terms, the retainer agreement should be in writing and must be terminable by the fund on a reasonable basis.

bio

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The trustees who want to retain control of the investment choices may feel that a professional trustee would have an outsized impact on investment decisions by virtue of their position. Trustees who have a low risk tolerance may prefer a conservative investment structure and be concerned that a professional trustee will seek to move them to a more aggressive approach that is in line with similar types of funds with similar asset values. A preference for a conservative investment portfolio must be balanced against the trustees' duty to act prudently with respect to investment decisions and diversify investment assets. The professional trustee should (if qualified) be able to consider the interplay between the plan's funding characteristics and its investment design and asset allocation. For example, in the case of a mature fund—one relying primarily on the existing assets to pay benefits because the ratio of accruals to contributions is high—the professional trustee could guide the board to work with the actuary and investment professionals to insulate the assets from investment risk to the extent possible.

Professional Trustee Credentials

There are no specific credentials necessary for a person or entity to hold themselves out as a professional trustee. But since, under ERISA, the expenditure of plan assets must be prudent under the circumstances, a professional trustee should have the expertise that justifies the cost. This may

include attending numerous trustee meetings over many years; dealing with a variety of fiduciary issues; experience with the Internal Revenue Service (IRS), DOL and Pension Benefit Guaranty Corporation (PBGC); experience with types of employee funds for which the professional trustee is being considered; and skill in dealing with the types of advisors that the funds retain.

Good candidates for the professional trustee role may include experienced employee benefits attorneys; former fund administrators; and longtime, experienced trustees. Investment professionals may be a good fit when the professional trustee is retained in connection with a particular investment decision. It is important to ensure that the person with the credentials will be the one performing the work.

Conclusion

Hiring a professional trustee may help multiemployer benefit funds navigate complex investment decisions, avoid prohibited transactions or mediate ongoing disputes among other tasks. Funds should make sure to evaluate a professional trustee's credentials and determine whether the cost of hiring a professional trustee is justified.

Endnotes

1. In many instances, the employer association may appoint the employer trustees in lieu of the employers.

2. The Department of Labor (DOL) has stated that if a fund's governing document (trust, collective bargaining agreement or plan document) contemplate that acts that otherwise would be settlor in nature are defined as fiduciary acts, they would be governed by Employee Retirement Income Security Act (ERISA) fiduciary rules. DOL *Field Assistance Bulletin 2002-02*.

3. By contrast, the settlor of a single employer fund is the entity that established the trust and has the authority under the authority to amend it. See ERISA Section 3(16)(b), 29 USC §1102((16)(b).

4. ERISA Sections 406(a) and (b); 29 USC §§1106(a) and (b).

5. ERISA Sections 408 (b) and (c); 29 USC §§1108(b) and (c).

6. Section 302((c)(5)(B) states that the trust agreement must provide that "the employer, and employees and employers are equally represented in the administration of such fund, together with such neutral persons as the representatives of the employers and the representatives of employees may agree upon and in the event the employer and employee groups deadlock on the administration of such fund and there are no neutral persons empowered to break such deadlock."

SSDI:

A Money-Saving Option for Multiemployer Health Funds and

Multiemployer health funds may discover that they can save money while providing a beneficial service to their pre-65 retirees by helping them apply for benefits through the Social Security Disability Insurance (SSDI) program.

Their Members?

by | **Kenneth B. Berry** and **Craig C. Horton**

Providing health benefits to pre-65 retirees and their dependents has become an expensive issue for many multiemployer health funds. Some plans are increasing member premiums or dropping their retiree health care plan altogether in response to rising costs.

One option that funds may be unaware of is potential savings to the fund and the value to members or dependents if they become eligible for income and Medicare benefits through Social Security Disability Insurance (SSDI).[1] SSDI is an insurance-based program for individuals who have paid into the Federal Insurance Contributions Act (FICA) for a sufficient number of years.

Most people are usually aware of SSDI primarily as a standard offset to long-term disability (LTD) insurance that private LTD carriers use to lower their liability. And SSDI is generally thought of as applying only to people who have lost their employment due to a serious disability. However, as the sidebar illustrates, SSDI may help members and funds in ways that some may not have considered.

SSDI Basics

SSDI provides a monthly cash benefit to eligible individuals (those who have paid FICA taxes) based on their earnings history and the amount of Social Security taxes they have paid. Individuals are eligible to apply for SSDI up to five years after they last paid into FICA. Following are some details of the program.

- If awarded SSDI, individuals will receive Social Security income equal to the amount they would have received if they retired at full retirement age (65-67, depending on the year they were born). By contrast, Social Security reduces benefits by 30% if they are claimed at age 62.
- The maximum SSDI benefit is about $3,808 per month[2] and has annual cost-of-living adjustments (COLAs). The average monthly benefit for disabled workers is about $1,486.[3]
- SSDI benefits can also include an additional 50% for a dependent under age 18.
- SSDI recipients automatically become eligible for Medicare two years after the onset date of the disability determined by SSA—no matter what age the claimant is.

SSDI can be a lifeline or key supplement to pensions for those who are unable to work due to their disability. It is a critical program for millions of Americans, providing financial support to those who would otherwise be unable to meet their basic needs.

SSDI, Medicare and Pre-65 Retirees

Here's a look at how SSDI eligibility would affect health coverage for pre-65 retirees.

- After two years, Medicare will become the primary payer for pre-65 retirees who are members/spouses of a multiemployer plan that offers retiree group health care coverage, as long as the retiree remains unemployed. The group plan will become secondary, potentially creating significant cost savings for the fund.
- Pre-65 retirees who have no trust fund subsidy and are paying the full group rate premium or are purchasing their own health insurance coverage will likely pay a significantly lower rate for any Medicare plan—whether it is traditional Medicare, Medicare Advantage or Medicare with a supplemental plan.
- For pre-65 retirees whose premiums are subsidized by the fund, there may still be savings when they move to Medicare.

The Opportunity

Most employers and funds are not fully aware of the benefits of SSDI, nor are members. Although individuals are eligible for SSDI benefits for five years after they last paid FICA taxes, most people assume that if they become disabled in retirement, they

takeaways

- Helping retirees who are under age 65 apply for Social Security Disability Insurance (SSDI) benefits may help multiemployer health funds save money and provide value to retirees.
- SSDI is an insurance-based program that provides a monthly cash benefit to individuals who have paid FICA taxes for a sufficient number of years and who meet the criteria for disability.
- If they meet the SSDI criteria, pre-65 retirees become eligible for Medicare two years after the award instead of having to wait until they turn 65. Their Social Security benefits also will be restored to the level they would have received had they retired at full retirement age.
- Savings for multiemployer health funds may result from an SSDI benefit award to a member because Medicare would become the primary payer of the member's health care claims.
- Funds may want to consider contracting with an advocate to assist members in applying for SSDI. Auditing Medicare eligibility data and conducting an educational campaign may also help identify members who may be candidates for SSDI.

don't have a way to get disability benefits. Members may be unaware of the benefits they became eligible for, such as SSDI, by paying into FICA and may be less likely to apply unless they are actively educated and receive guidance and support.

SSDI Application Process and Criteria

Following is the typical process of applying for an SSDI award. An individual may not have to go through all the steps to receive a final decision.

1. Initial application
2. Reconsideration
3. Administrative hearing
4. Appeals Council

The criteria for determining disability are complex. SSA defines *disability* as the inability to engage in any substantial gainful activity (SGA) because of a medically determinable physical or mental impairment(s) that is either expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months.[4]

After receiving an SSDI application, SSA follows a sequential decision-making process in order to determine whether the claimant meets the criteria for a disability award.

1. **Is the claimant performing any SGA?**
   If the claimant is working and their earnings average more than a certain amount each month, SSA generally

Member Example

Here is a hypothetical example of how a multiemployer fund may assist a member in applying for Social Security Disability benefits and save money for the fund and the member.

Joe finally retired at 57 after years of chronic back pain that severely limited his strength and mobility. He was diagnosed with degenerative disc disease of the lumbar spine. He has a moderate to severe condition, and his doctor says that functionally he is limited to sitting two hours and standing/walking two hours in an eight-hour workday.

Joe's annual average salary for the purpose of calculating his Social Security retirement benefit is $75,000.

Joe's 58th birthday was January 1, 2023, and he filed for his SSDI on that date. On January 1, 2024, Joe receives a letter from Social Security that his application was approved, retroactive to his filing date. Along with his award letter, Joe receives a check for $33,600, representing 12 months of retroactive pension benefits from the date he applied for SSDI. He also begins receiving his monthly pension payment of $2,800.

On January 1, 2025, Joe becomes eligible for Medicare. This means that Joe will have Medicare coverage five years earlier than the normal age of 65. Joe may also benefit from a lower out-of-pocket premium and other costs for Medicare coverage or may also purchase a Medicare Advantage or Medicare Supplement policy with lower costs or additional benefits.

At this point, Medicare becomes the primary payer, and the multiemployer fund will have the benefit of paying Joe's claims as secondary five years earlier than if Joe had not received his SSDI award.

A common way to estimate savings to the fund is to start with Medicare's average annual per person expenditure, which includes inpatient and outpatient treatment and prescription drug costs. The estimated per-person expenditure for 2023 is $17,042.* Disabled participants are an estimated two to three times more costly than nondisabled participants.** Conservatively estimating a 40% greater cost, first-year savings to the fund can be estimated at $23,859 and will continue for an additional four years.

Total Plan Savings and Member Value

- Total SSDI benefits (without COLAs) nine years before normal retirement age: $302,400
- Total self-pay savings based on Medicare eligibility for five years (estimated at $1,000 per month premium cost): $60,000
- Estimated multiemployer fund savings from five years of Medicare primacy: $132,322

Example Endnotes

**2023 Medicare Trustees Report*. Table V.D1.
***"CHRIL Article Examines Health Care Coverage and Costs for People with Disabilities," National Disability Navigator Resource Collaborative, January 11, 2018. Retrieved May 24, 2023 from https://nationaldisabilitynavigator.org/2018/01/11/chril-article-examines-health-care-coverage-and-costs-for-people-with-disabilities.

bios

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does not consider them disabled. The monthly amount changes each year. Self-care, household tasks, school attendance, social programs and unpaid job training are examples of activities not considered to be SGA.

2. **Is the medical condition severe?**
   The claimant's condition must significantly restrict work-related activities for the claim to be considered. If it does not, the claimant will not be considered disabled.
3. **Is the claimant's condition found in the list of disabling conditions (list of impairments) maintained by SSA?**
   If the claimant's condition is not on the list, SSA must decide whether it is of equal severity to a medical condition that is on the list. If it is, SSA will find the claimant disabled. If it is not, they then go to step 4.
4. **Can the claimant do the work they did previously (past relevant work)?**
   If the claimant's condition is severe but not a similar or equal level of severity as a medical condition on the list, then SSA must determine whether it interferes with the claimant's ability to do the work they did previously. If it does not, the claim will be denied. If it does, SSA proceeds to step 5.
5. **Can the claimant do any other type of work?**
   If the claimant cannot do the work they did in the past, SSA decides whether the claimant can adjust to other work in the national economy. SSA considers the claimant's medical conditions, age, education, past work experience and any transferable skills they may have. If the claimant cannot perform other work, the claim will be approved.

Barriers

Each level of the SSDI application process can be difficult for an individual attempting the process alone. They will be required to fill out detailed government forms, submit medical records, complete questionnaires and much more. Depending on the state where the application is first filed, the waiting times for the average application decision can be up to nine months. If the application is initially denied, then the reconsideration and hearing step can add another three to 18 months before the final decision. Overall, less than 40% of individuals who apply are ultimately approved for their disability award.[4]

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The length and complexity of the process causes many applicants to give up and not continue to pursue their case. Success rates greatly improve when professional disability representation is involved—particularly at the application level.[5] However, most professional representation is only sought after an application has been denied. When representation is sponsored by a fund or other organization before an application is filed, success rates can be greatly improved.

The process can take several months to several years.

Advocates

SSA recognizes the complexity of its disability criteria and controls who can advocate for someone filing for SSDI and receive compensation. The two options are:

1. Licensed attorneys
2. Eligible direct pay nonattorney (EDPNA) representatives, who are licensed by SSA. They must successfully complete an exam and satisfy annual continuing education requirements.

SSA also limits the compensation the attorney/advocate can receive when assisting a disabled person in their filing of an SSDI claim to a maximum of 25% of the retroactive award amount up to a maximum of $7,200.

Advocates understand the process and conditions and will assist in putting together the strongest possible application, can manage the paperwork and will go through every stage of the process.

Putting It All Together

Following are steps that funds can take to maximize the SSDI opportunity.

1. **Audit the fund's Medicare eligibility data to make sure all those who are eligible according to the Medicare administrator (Center for Medicare and Medicaid Services (CMS)) are correctly identified in the fund's records.**
   Mandatory data exchanges that have been required since 2010 under the 2007 SCHIP Extension Act by the CMS were designed to ensure that CMS was not paying for individuals who are not eligible for Medicare. However, the mandatory exchanges are not sufficient to identify every Medicare-eligible individual who is not on Medicare. Relying on or requiring self-reporting by individuals is also not reliable. Only a program using queries focused on a particular population and continuous error checking can assure 100% accurate reporting.
2. **Engage in an educational campaign about SSDI.**
   The fund can develop an educational outreach campaign directed at pre-65 retirees who may be eligible for SSDI. Providing ongoing education through mailers or email or on the fund's website about SSDI benefits and eligibility to all pre-65s will help increase awareness of the availability of SSDI and Medicare. Direct outreach via email or mailers that include a simple health status questionnaire, to either all or specific members identified through claims analysis, may increase the number of eligible members who will apply and ultimately be awarded benefits.
3. **Engage an experienced, SSA-qualified representative or firm.**
   Beyond professional licensure and experience, the fund should ask for at least three references from previous clients. These representatives can assist pre-65 retiree members or their spouses who may be disabled to apply for SSDI.

Conclusion

SSDI and early Medicare are often-overlooked cost-containment programs for multiemployer funds to implement that may mitigate costs for pre-65 retirees and dependents. They are unique compared with other cost-containment programs because they have the potential to improve benefits to these participants.

Endnotes

1. Supplemental Security Income (SSI) is also administered by the Social Security Administration but is a needs-based program designed for individuals who did not pay sufficiently into Social Security (FICA) and typically qualify for Medicaid.
2. www.ssa.gov/oact/cola/examplemax.html. Maximum current monthly benefit for workers who were employed steadily at maximum Social Security taxable rate.
3. www.ssa.gov/policy/docs/quickfacts/stat_snapshot. "Monthly Statistical Snapshot—June 2023." Table 2.
4. www.ssa.gov/redbook/eng/definedisability.htm?tl=0.
5. "Annual Statistical Supplement to the Social Security Bulletin," 2022. *SSA Publication No. 13-11700*, released December 2022. Table 6.C7.
6. *Legal Representation in Disability Claims*, National Bureau of Economic Research, July 2021. www.nber.org/sites/default/files/2023-06/NB19-29%20Hoynes%2C%20Maestas%2C%20Strand%20FINAL_0-VD.pdf.

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39 **No USERRA Violation by Employer Limiting Tuition Assistance Eligibility**
The Eighth Circuit affirms a grant of summary judgment since the plaintiff's military veteran status was not a motivating factor in the defendant's decision to deny tuition assistance benefits.

41 **Denial of Disability Benefits Was Reasonable**
The Seventh Circuit affirms the district court's order granting the defendant's motion for summary judgment regarding the decision to deny the plaintiff disability benefits.

43 **Court Permits Class Action on Recordkeeping Fee Theory, Rejects Management Fee Theory**
A district court partially grants the defendants' dismissal motion; the plaintiffs lack standing for a management fee theory but have it for a recordkeeping fee theory.

45 **Parties Ordered to Discuss Disability Benefits Dispute After Administrator's Mistaken Denial**
A district court orders the parties to propose a schedule for final resolution of the matter because the plaintiff established that the defendant erroneously denied benefits under ERISA.

47 **Court Allows Life Insurance Conversion Dispute to Move Forward**
A district court grants in part and denies in part the defendant employer's motion to dismiss because some of the plaintiff's claims regarding a life insurance conversion process are plausible.

49 **Motion for Default Judgment Granted in Missed Contributions Dispute**
A district court grants the plaintiff's motion for judgment by default and orders the defendant to provide the plaintiff with outstanding remittance reports and corresponding contributions.

50 **Termination of Nonqualified Deferred Compensation Plan Ends Future Payment Obligations**
A district court dismisses the defendants' counterclaims and motion for judgment because they are preempted by ERISA and the plaintiff properly terminated its obligations to the defendants.

51 **Salary Continuation Program Claim Fails Due to Filing Outside of Limitations Period**
A district court grants the defendants' motion to dismiss and dismisses the plaintiff's short-term disability breach of contract claim because the plaintiff brought it outside the contractual limitations period.

53 **Arbitrator's Award in Withdrawal Liability Action Confirmed**
A district court denies the plaintiff's motion for summary judgment, grants the defendant's motion for summary judgment and confirms the arbitrator's award.

55 **Washington Update: Guidance on HIPAA and Cybersecurity Authentication**

No USERRA Violation by Employer Limiting Tuition Assistance Eligibility

The U.S. Court of Appeals for the Eighth Circuit affirms the district court's order granting the defendant's motion for summary judgment because the plaintiff's status as a military veteran was not a motivating factor in the defendant's decision to deny tuition assistance benefits.

The plaintiff is a former military service member who is an employee of the defendant. The defendant is the plaintiff's employer, which provides tuition assistance benefits to its employees under a tuition assistance plan.

After leaving the military, the plaintiff enrolled in a bachelor's degree program and began working for the defendant. Under the plan, participating employees could have their tuition costs and other fees reimbursed up to a certain maximum amount. However, the plan provides that tuition assistance is not available to employees receiving tuition assistance from other sources unless these sources do not cover the tuition in full. Due to the plaintiff's military service, he was also eligible for education benefits under the G.I. Bill. The G.I. Bill provides eligible recipients with educational assistance benefits to be used to cover expenses related to a recipient's subsistence, tuition and other educational costs. Benefits are paid directly to eligible recipients, and the monthly benefit amount depends on the type of education the recipient is pursuing as well as the number of courses taken.

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When the plaintiff applied for the tuition assistance benefits under the plan, the defendant initially approved the application and paid benefits directly to the university where the plaintiff was taking classes. At the time, the plaintiff was not receiving G.I. Bill benefits because he was still filling out the paperwork associated with getting approved. Shortly thereafter, the plaintiff began receiving G.I. Bill benefits, including benefits that retroactively compensated him for the courses he had already completed. The plaintiff notified the defendant of receipt of the G.I. Bill benefits and, as a result, the defendant denied the plaintiff's application for additional tuition assistance benefits because the plaintiff was receiving duplicate educational aid. The defendant obtained reimbursement from the university for the amount it had previously paid for the plaintiff's tuition. The amount was then covered by the plaintiff's G.I. Bill benefits.

The plaintiff sued the defendant in the district court, claiming that the denial of tuition assistance benefits based on his receipt of G.I. Bill benefits amounted to unlawful discrimination under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Specifically, the plaintiff alleged that the defendant violated his rights under USERRA by denying him tuition assistance benefits he otherwise would have received but for his service in the military. The district court found that offsetting tuition assistance by the amount an employee receives through G.I. Bill benefits is not the same as denying tuition assistance benefits on the basis of an employee's military status. Consequently, the district court granted summary judgment in the defendant's favor, and the plaintiff appeals the district court's decision.

USERRA prohibits employment discrimination based on military service and provides that a person who has performed service in the military

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BENEFIT DENIAL

No USERRA Violation

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shall not be denied any benefit of employment by an employer based on that past service. A *benefit of employment* includes any advantage, profit, privilege, gain, status, account or interest that accrues by reason of an employer's policy, plan or practice. An employee alleging a discrimination claim under USERRA must make the initial showing that military status was a motivating factor in the adverse employment action at issue. The employer can then defeat the claim by proving by a preponderance of evidence that the action would have been taken despite the protected status.

On appeal, the plaintiff challenges the district court's conclusion that the plaintiff failed to make an initial showing that his military status motivated the defendant to deny him benefits. The plaintiff argues that he offered both direct and circumstantial evidence upon which a reasonable jury could find that his military service was a motivating factor in the defendant's decision.

First, the plaintiff alleges that the defendant's admission that it denied him benefits because he was also receiving G.I. Bill benefits is direct evidence of discrimination based on his status as a military veteran. But the court finds that under the plain language of the plan, veterans who are not eligible to receive G.I. Bill benefits could have qualified for benefits under the plan. Thus, a policy that conditions an employee's eligibility for an employment benefit on whether the employee is receiving similar benefits from another source does not necessarily discriminate against employees who have served in the military. Also, under the plan, employees who served in the military are eligible to receive benefits even if they also received G.I. Bill benefits, so long as those benefits did not cover their tuition costs in full.

The defendant responds that as part of its motion for summary judgment, the defendant proffered evidence that one employee who received G.I. Bill benefits that only covered part of his tuition expenses was deemed eligible for tuition assistance benefits under the plan and was accordingly reimbursed for the remaining part of his tuition costs. The court finds that the defendant's evidence underscores that the defendant did not deny benefits to all military veterans, or even to all military veterans who also received G.I. Bill benefits. Also, under precedent case law, the fact that one of the sources of one's additional disability benefits relates to one's veteran status is not enough to plausibly allege a violation of USERRA's antidiscrimination provision.

Next, the plaintiff alleges that circumstantial evidence in the record supports the reasonable inference that his status as a military veteran was a motivating factor in the defendant's decision to deny him tuition assistance benefits. The plaintiff argues that after he contacted the defendant to challenge its denial decision, the defendant HR administrator treated the plaintiff with hostility. The plaintiff argues that the HR administrator's behavior qualifies as undisputed evidence of the defendant's animus toward the plaintiff's military status.

But as the district court noted, although the communications from the HR administrator indicate her frustration with the plaintiff, this does not disparage the fact that the plaintiff was a military veteran or express hostility toward veterans more generally. Thus, the district court found that the HR administrator's behavior failed to give rise to an inference of discrimination based on the plaintiff's military status. The plaintiff also argues that a comment from the HR administrator suggesting that the defendant would not have denied him benefits if he had simultaneously received tuition support from a "rich aunt" shows that it is discriminatory against military service members. The court notes that the plan is not unlawfully discriminatory toward veterans and service members merely because it does not encompass every plausible nonmilitary source of duplicative education funding. Consequently, the court agrees with the district court that the record evidence on which the plaintiff relies fails to create a genuine factual dispute from which a reasonable jury could find that the defendant violated USERRA.

Accordingly, the court finds that the plaintiff fails to present sufficient evidence to show that his status as a military veteran was a motivating factor in the defendant's decision to deny him education assistance benefits and, therefore, the court affirms the district court's order granting the defendant's motion for summary judgment.

Kelly v. Omaha Public Power District, No. 22-2321 (Eighth Cir., July 28, 2023).

Denial of Disability Benefits Was Reasonable

DISABILITY BENEFITS

The U.S. Court of Appeals for the Seventh Circuit affirms the district court's order granting the defendant's motion for summary judgment because the defendant's decision to deny disability benefits to the plaintiff was reasonable.

The plaintiff is a former union ironworker. The defendant is a pension trust fund established to provide retirement and disability benefits to union members. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff suffered various injuries and applied for disability insurance benefits under the plan. Eligibility for disability benefits under the plan is based on how many pension credits an ironworker has accumulated (a credit is equal to 1,000 hours of work on union jobs in a given year). The plan assigns a certain number of credits to union members in accordance with the number of accumulated hours of work. A higher number of credits entitles a member to disability benefits upon becoming "totally and permanently disabled," which the plan defines as entitled to disability payments under the Social Security Act. A lower number of credits also entitles a member to disability benefits, but subject to the additional requirement that the claimant must be "totally and permanently disabled" as the result of an accident sustained while on the job with a contributing employer of the plan.

The plaintiff earned a lower number of credits that entitled him to claim disability in accordance with this category. Because the Social Security Administration (SSA) had previously approved the plaintiff's application for Social Security Disability Insurance, this award satisfied the plan's requirement that the plaintiff be "totally and permanently disabled." But because the plaintiff was in the lower credit category, he still needed to show that his disability was work-related.

When the plaintiff applied for disability benefits under the plan, the defendant rejected his application because the plaintiff failed to connect his disability to an on-the-job injury. The defendant noted that the SSA award letter did not explain why it concluded that the plaintiff was disabled. Also, the defendant reviewed the plaintiff's work history and determined that more information was needed to connect the plaintiff's disability to an on-the-job injury. When the defendant asked for medical records that the SSA relied on, the plaintiff admitted that his award was determined by a combination of factors and not just an on-the-job injury. Consequently, the defendant concluded that none of the records, including the plaintiff's workers' compensation file and a letter from the plaintiff's physician, connected his disability to an on-the-job injury. The plaintiff internally appealed the denial, but the additional evidence and a report from an independent medical reviewer did not change the decision. The plaintiff filed suit in federal court under ERISA. Both sides moved for summary judgment, and the district court ruled in favor of the defendant, finding that the decision to deny the benefit was not unreasonable.

The plaintiff alleges that he was not allowed to respond to certain evidence on which the defendant relied on appeal. ERISA requires a claimant to be provided the opportunity to review and comment on any materials that might be considered before adjudicating a claim. First, the plaintiff argues that the defendant's failure to provide him with a copy of the independent medical examiner's report violated ERISA. The court finds that normally this would require a remand because the failure to let a claimant respond to newly produced evidence denies him the full and fair review that ERISA requires. However, the defendant argues that the plaintiff did not make this argument to the district court. Consequently, because appellate courts in general do

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Denial of Benefits Was Reasonable

continued from previous page

not consider arguments not presented in lower courts, the court waives the plaintiff's argument on appeal.

The plaintiff next alleges that the defendant's decision was irrational and overlooked crucial evidence. Because the plan confers discretion on the defendant as the plan administrator to determine eligibility for benefits, the court gives deference to the defendant's decision under the deferential arbitrary-and-capricious standard. The court finds that under the conditions that claimants are entitled to payment if they become "totally and permanently disabled as the result of an accident sustained while on the job," the phrase *as a result of* is not a self-defining term. The interpretation of that phrase falls to the defendant, which the plan makes the sole judge of the standard of proof. Also, the plan gives the defendant discretionary authority to determine whether an applicant is eligible for benefits.

Further, the court finds that the evidence examined by both the defendant and the medical reviewer shows that there was no clear connection tying the defendant's disability to a workplace injury. Because of the scarcity of causation evidence between the on-the-job injury and the plaintiff's disability, this conclusion was far from arbitrary. Also, the defendant may have relied on the medical reviewer's conclusion so long as the reviewer provided a nonarbitrary explanation for his conclusion. Consequently, the court finds it was reasonable for the defendant to conclude that no causal connection between the plaintiff's on-the-job injury and his disability existed.

In addition, the court is not persuaded by the plaintiff's counterarguments. First, the plaintiff alleges that the defendant added a new benefit eligibility requirement found nowhere in the plan and that the SSA's letter specified why it awarded benefits. The court disagrees with this argument because the defendant looked for and considered other evidence to find causation between the plaintiff's on-the-job injury and his disability and did not simply rely on the SSA's letter.

The plaintiff next alleges that the defendant should have sought more information to support the plaintiff's claim. The court finds that although the defendant could have gathered more evidence, the defendant had no duty to do so. Although ERISA contemplates a collaborative process for adjudicating claims, plan administrators have limited time and resources, and the claimant is usually best positioned and best motivated to provide information to support the claim. Also, the defendant sought greater information, circled back with the plaintiff for more evidence, and offered guiding questions to help the plaintiff's chances. Despite these efforts, the plaintiff provided no new evidence.

Next, the plaintiff alleges that the defendant ignored credible evidence in the record connecting his disability to a workplace injury. The court finds that the plaintiff misread the language of the plan because a work-related disability is not enough to receive benefits under the plan—A claimant must be entitled to disability payments under the Social Security Act as the result of an on-the-job accident. Although the plaintiff might have suffered an on-the-job injury, that does not mean that the plaintiff's entitlement to disability payments stemmed from that injury.

Finally, the plaintiff alleges that the defendant asked the medical reviewer the wrong question. The plaintiff argues that rather than asking whether the SSA award was connected to a workplace injury, the defendant should have asked whether the plaintiff's workplace injury was a disabling condition. The court disagrees and finds that such an alternative, open-ended inquiry would not track the plan's unambiguous requirement that claimants be entitled to disability payments under the Social Security Act.

Accordingly, the court agrees with the district court's conclusion that the defendant acted well within its discretion in denying the plaintiff's disability benefits claim and, therefore, affirms the district court's entry of summary judgment in favor of the defendant.

Lane v. Structural Ironworkers Loc. No. 1 Pension Trust Fund, No. 22-1149 (Seventh Cir., July 17, 2023).

Court Permits Class Action on Recordkeeping Fee Theory, Rejects Management Fee Theory

FIDUCIARY DUTIES

The U.S. District Court for the District of Colorado grants in part and denies in part the defendants' motion to dismiss because the plaintiffs lack standing to bring their claim under a management fee theory, but they can do so under a recordkeeping fee theory.

The plaintiffs are a class of former employees of the defendant who participated in the employer-sponsored retirement plan. The defendants include the employer sponsoring the plan, the employer's board of directors, the plan's administrative committee and multiple individual plan fiduciaries. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plan is a defined contribution plan in which employees, including the plaintiffs, elected participation and directed their investments within the options made available through the plan. Plan participants, including the plaintiffs, incurred several fees, including management and recordkeeping fees. The plaintiffs allege they and other plan participants were subjected to unreasonably high fees because the defendants failed to prudently select appropriate investment options and appropriately negotiate reasonable recordkeeping fees in accordance with their fiduciary duties under ERISA.

The plaintiffs allege the unreasonable cost of certain investment options and argue that the defendants did not engage in a prudent process of identifying and removing investment options with unreasonable fees. The management fees depended on the investment options and their expense ratios that the plaintiffs selected. The plaintiffs identify some of the plan's mutual funds as having materially higher expense ratios than the average expense ratios of similar funds.

Next, the plaintiffs allege high recordkeeping fees and argue that several large recordkeepers offer relatively fungible services, which results in prudent fiduciaries regularly using this bargaining power to shop for lower rates. Throughout the putative class period, the plan used only one recordkeeper and never conducted a request for proposals to compare rates and services. The plaintiffs claim that the plan participants paid both flat direct fees and indirect fees, which are paid as a percentage of the value of the investments, despite prudent fiduciaries being able to negotiate recordkeeping fees as a fixed dollar amount to avoid paying more for services that should become cheaper as the plan grows. The plaintiffs argue that these excessive fees demonstrate that the defendants breached their duty to prudently monitor recordkeeping fees and prevent the plan from paying unreasonable rates.

With respect to the management fees, the defendants argue that the plaintiffs cannot show they were personally injured by the allegedly imprudent investment options made available by the plan because the plaintiffs did not invest in any of the challenged funds. The defendants argue that under such circumstances, courts have uniformly held that plaintiffs lack standing to assert imprudent investment claims under ERISA. The plaintiffs counter that courts have found that plaintiffs do not need to make a showing of investment in each fund to demonstrate standing.

The court finds that for the plaintiffs to have standing to sue on behalf of absent putative class members, they must have elected to invest in at least one such fund. Because none of the plaintiffs invested in any of the challenged funds, the court finds the plaintiffs lack standing to bring their breach of fiduciary duty claim under the management fee theory.

With respect to the recordkeeping fees, the defendants argue that the plaintiffs have not suffered any injury because, while the annual per-participant recordkeeping fees paid by the plan exceeded a certain benchmark identified as reasonable, the

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Court Permits Class Action
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plaintiffs themselves paid lower fees during the putative class period. The plaintiffs respond that because their claims are brought on behalf of the plan, the fact that they personally paid less than the benchmark fees does not mean the fees were reasonable. The plaintiffs argue that many of the plan's recordkeeping fees were bundled, so the plan paid a flat, per-participant fee. Therefore, if the plan was paying unreasonable recordkeeping fees, a refund of a portion of those fees would benefit all participants, including the plaintiffs. The court finds that the plaintiffs have suffered a particularized injury with respect to the recordkeeping fees and, consequently, have standing to sue under the recordkeeping fee theory.

With respect to their motion to dismiss, the defendants argue that during the class period, the plan paid recordkeeping fees that are comparable with the benchmark fee ranges that the plaintiffs present in the complaint, so the plaintiffs cannot allege that the defendant failed to secure reasonable recordkeeping fees. In addition, the defendants point to an inconsistency in the methodologies used to calculate the recordkeeping fees paid by the plan and allegedly comparable plans. Further, the defendants argue that the plaintiffs' use of another recordkeeper's stipulation in another lawsuit as to the value of recordkeeping services is irrelevant because it reflects the value provided in a different context and under different contracts. The plaintiffs respond that any miscalculations of comparator-plan fees are inconsequential, and the defendants do not deny that the plan is more expensive than the average plan. Also, the plaintiffs argue that alleging using another recordkeeper's stipulation as to the value of recordkeeping services is enough to survive a motion to dismiss because comparing the services and fees of different recordkeepers is fact-intensive and inappropriate at this stage of the litigation.

The court finds that the plaintiffs' comparator-plan allegations fail to plausibly allege imprudence because the comparisons attempt to allege imprudence through an apples-to-oranges comparison. However, the court finds that the fact-intensive nature of comparing the recordkeeping services should not be done at this stage of the litigation. Therefore, the court assumes as true the allegations that the plan was paying a higher recordkeeping fee for a service that was worth much less.

Accordingly, the court finds that the plaintiffs lack standing to bring their breach of fiduciary duty claim under a management fee theory, but they have stated a claim upon which relief can be granted under a recordkeeping fee theory, so the court grants in part and denies in part the motion to dismiss.

Teodosio et al. v. Davita, Inc., et al., No. 1:22-cv-00712-WJM-MDB (D.Colo., July 26, 2023).

Parties Ordered to Discuss Disability Benefits Dispute After Administrator's Mistaken Denial

The U.S. District Court for the Eastern District of California orders that the parties meet and confer and file a status report proposing a schedule for final resolution of the matter because the plaintiff established that the defendant erroneously denied benefits under the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff is a participant in an employee benefits plan that includes long-term disability (LTD) benefits. The defendant is an insurance company and the LTD benefit administrator for the plan. The plan is governed by ERISA.

Under the plan, if an employee's disability is attributable to a certain condition, benefits are paid for only 24 months, even if the disability persists beyond that period. However, an employee may continue to receive benefits beyond that period if the disability has "objective evidence" of at least one of the six qualifying conditions. The plaintiff suffers from a condition that prevents him from working. By the terms of the plan, the plaintiff received 24 months of disability benefits, but the parties dispute whether there is objective evidence of any qualifying conditions to entitle the plaintiff to continued benefits.

The plaintiff's physician originally diagnosed the plaintiff with a qualifying condition, but he did not provide the reasons and testing supporting the diagnosis. The defendant did note repeatedly in its internal records that the plaintiff was out of work due to a qualifying condition, but none referred to any medical imaging or similar test results supporting the condition. However, other portions of the plaintiff's medical records, including from the plaintiff's pain management doctor, expressly rule out that he suffers from the qualifying condition, but these records also do not provide the reasons and testing supporting the lack of the diagnosis. Other portions of the plaintiff's medical records are silent or ambiguous.

When the defendant reviewed these medical records, it found no objective evidence of the qualifying condition, so it informed the plaintiff that he did not qualify to receive benefits beyond 24 months. The plaintiff appealed that decision in an internal administrative process. In response, the defendant hired an independent medical reviewer who found no objective evidence of a qualifying condition. The plaintiff responded with additional medical reports that had not been completed at the time of the original denial. However, the new information did not change the medical reviewer's opinion. Consequently, the defendant upheld its decision to deny disability benefits beyond 24 months, citing a lack of objective evidence of a qualifying condition. The plaintiff then filed suit to recover disability benefits due under the terms of the plan.

The court notes that interpretive rules require that any ambiguities in a policy's terms be resolved in favor of the plan participant or beneficiary and that courts construe exclusions in favor of coverage. First, the court finds that under the plan, the term *disability* is a status that is the satisfaction of several conditions. The court interprets the plan as requiring objective evidence of one or more of the qualifying conditions to support the conclusion that the plaintiff is disabled. Second, the court finds that the plan does not say how conclusive or extensive the objective evidence of a qualifying condition must be. For example, the plan does not specify whether evidence of a qualifying condition rules out other potential causes of disability. The court finds that the plan could reasonably be interpreted as asking for some objective evidence, not conclusive evidence, that tends to prove a qualifying condition. Further, the court finds that if the plan wanted to require definitive condition of a qualifying evidence, the plan could demand evidence proving or establishing a qualifying con-

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BENEFIT DENIAL

Parties Ordered to Discuss Disability Benefits Dispute

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dition. Consequently, the court finds that it must construe the policy in favor of coverage and resolve ambiguities in the plaintiff's favor.

Further, the court finds that some of the plaintiff's evidence is not "objective," as required under the plan. The plaintiff's reports of pain and numbness are personal and subjective, and the defendant's internal records and physician's notes are mere conclusions that one might draw from objective evidence. However, the court finds that some other evidence in the record, such as clinical observations, is objective and not disputed by the defendant. The court finds that clinical observations do not conclusively prove that the plaintiff suffers from the qualifying condition, but the court also notes that the plan does not require conclusive evidence.

The defendant relies on several arguments to minimize this evidence. First, the defendant argues that the medical reviewer's opinions show no objective evidence of the qualifying condition. But the court rejects this argument because it finds that the plan does not require objective evidence excluding other causes and supporting a conclusive diagnosis. Second, the defendant argues that some of the plaintiff's records do not refer at all to the possibility of the plaintiff suffering from the qualifying condition. However, the court finds that the defendant does not point to any plan policy provisions permitting it to deny benefits based on negative inferences. Lastly, the defendant argues that some of the plaintiff's records specifically state that the plaintiff does not have the qualifying condition. However, the court finds that these records are conclusionary physician's notes that are not objective evidence, as required under the plan. Also, the court finds that the plan does not require that evidence supports the plaintiff's claim uniformly.

Accordingly, the court finds that the defendant erroneously denied disability benefits and orders the parties to meet, confer and file a status report proposing a schedule for the final resolution of the matter.

Sutton v. Metropolitan Life Insurance Co. et al., No. 2:22-cv-00732-KJM-CKD (E.D.Cal., July 20, 2023).

Court Allows Life Insurance Conversion Dispute to Move Forward

The U.S. District Court for the Northern District of Indiana grants in part and denies in part the defendant employer's motion to dismiss because some of the plaintiff's claims regarding a life insurance conversion process are plausible.

The plaintiff is a widow whose deceased husband was a participant in an employee benefits plan sponsored by his employer and administered by an insurance company. The defendants include the plaintiff's husband's employer and the insurance company that administered the life insurance benefits under the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff's husband was enrolled in a group life insurance policy under the plan. The plan documents provide that participants can elect to convert group life insurance coverage to an individual life policy if their employment is terminated. The plan documents direct participants to ask the defendant employer for a conversion application form and then submit it to the defendant insurance company with a check for the first premium.

After the plaintiff's husband was diagnosed with a malignant brain tumor and placed on long-term disability (LTD), the defendant insurance company sent him a letter informing him that his policy was expiring and that he could convert the policy to a whole life insurance policy within 90 days of the end of his group life coverage. The plaintiff's husband did not receive the letter because he was hospitalized. However, he later contacted the defendant employer to ask about his life insurance. The defendant employer gave him two different deadlines, one of which had expired, by which he had to convert his insurance to an individual policy by contacting the defendant insurance company. The plaintiff's husband never contacted the defendant insurance company and died. When the plaintiff tried to collect the death benefit, she learned that the conversion process had never been completed.

The plaintiff alleges that the defendant employer breached its duty as an ERISA fiduciary by providing misleading information to her husband regarding portability of the life insurance policy under the plan and improper information about the election form, as well as failing to complete and submit his election form to port the life insurance policy. Specifically, the plaintiff argues that the defendant employer gave her husband misleading and contradictory information about whether a deadline to initiate the conversion process had expired. In addition, the plaintiff argues that the defendant employer had a duty to initiate the conversion process with the defendant third-party administrator on her husband's behalf and that the conversion process was confusing and unreasonable.

The defendant employer argues that the plaintiff's claims should be dismissed because the defendant did not breach its fiduciary duties and the plaintiff did not suffer any harm. The defendant employer points to precedent case law that although it has a duty under ERISA to provide accurate information, negligence in fulfilling that duty is not actionable. Under the precedent, an employer must set out to disadvantage or deceive its employees for a breach of fiduciary duty to be made out. Because the plaintiff alleges that the misstatement resulted from confusion about the mechanics of the conversion process, the defendant employer argues that the required intent is missing. The plaintiff counters that precedent case law does not hold that an intent to deceive was required for a breach of fiduciary duty claim. Instead, evidence that the fiduciaries intended to mislead the participants can establish a violation of the duty of loyalty.

The court disagrees with the plaintiff's interpretation of precedent case law. Although a breach

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of fiduciary duty claim premised on a misstatement requires an intent to deceive, the plaintiff does not allege an intent to deceive. Instead, the plaintiff alleges a negligent misstatement, which is not actionable under ERISA because a plan fiduciary does not breach its fiduciary duties under ERISA by merely providing negligent misinformation about the contours of a plan.

Next, the plaintiff alleges that the defendant employer had an affirmative duty to take a more active role in the conversion process. The plaintiff argues that the defendant employer knew that the plaintiff's husband had serious health problems and, therefore, was unlikely to initiate the conversion process on his own. Because the plaintiff's husband called the defendant employer, it also knew that he wanted to convert the policy.

In considering this argument, the court finds that a review of plan documents is vital when determining whether a breach of fiduciary duty occurs under ERISA. If plan documents are clear and the fiduciary oversees its agents' advice to the participants, the fiduciary is not held liable if a ministerial, nonfiduciary agent gives incomplete or mistaken advice to a participant. However, if a fiduciary supplies the insureds with plan documents that are silent or ambiguous on a recurring topic, the fiduciary may be liable for the mistakes that plan representatives might make in answering questions on that subject.

The court finds the plan documents show not just ambiguity, but also show conflict on how a participant obtains a conversion application. The plan's summary plan description directed the plaintiff's husband to contact the defendant employer to obtain the conversion application. But when he did so, the defendant employer told him to contact the defendant insurance company. The court finds that at this stage it is impossible to conclude which set of instructions was correct; therefore, it does not dismiss this claim.

Further, the court disagrees with the defendant employer's response that ERISA does not require plan administrators to investigate each participant's circumstances and prepare advisory opinions for each participant. The issue here is not the defendant employer's lack of investigation but that the defendant employer and the defendant insurance company gave the plaintiff's husband conflicting information. Consequently, at the pleading stage, the court cannot say that the plaintiff has no cause of action when the plaintiff's husband did what the plan documents told him to do.

Finally, the defendant employer argues that its conduct did not cause the plaintiff's damages because the plaintiff's husband never followed directions to contact the defendant insurance company. The defendant employer relies on precedent case law where a plan participant failed to show a breach of fiduciary duty when he was mistakenly assured that he was automatically covered under his employer's health insurance plan when the plan documents made it clear that he was not. Because of the clear plan document language, there was no duty to emphasize something that had already been clearly communicated. However, the court finds that the cited case law is distinguishable because the plan is not clear when compared with the information the defendant employer and the defendant insurance company provided to the plaintiff's husband. Consequently, the court finds that if the defendant employer's failure to provide the conversion application was a breach, then the plaintiff's inability to obtain the death benefit was proximately caused by that breach.

Accordingly, the court finds that some of the plaintiff's claims are plausible, so the court grants in part and denies in part the defendant employer's motion to dismiss.

Burkett v. The Heritage Corp. et al., No. 1:22-CV-00405-HAB-SLC (N.D.Ind., July 18, 2023).

Motion for Default Judgment Granted in Missed Contributions Dispute

The U.S. District Court for the District of Columbia grants the plaintiff's motion for judgment by default and orders the defendant to provide the plaintiff with outstanding remittance reports and corresponding contributions because the plaintiff sufficiently alleges facts to support the claim of unpaid contributions.

The plaintiff is a multiemployer pension plan benefiting members of a labor union. The defendant is a contributing employer to the plan pursuant to a collective bargaining agreement (CBA). The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits that the plan provides are financed by contributions from employers that are parties to a CBA with labor unions. CBAs govern the defendant's responsibility to submit monthly remittance reports and pay monthly benefit contributions to the plaintiff. In violation of the CBA, the defendant reported but failed to pay the plaintiff a number of monthly contributions. The plaintiff alleges that it is entitled to unpaid contributions and argues that under ERISA and the CBA, it is also entitled to prejudgment interest from the due date of each unpaid monthly contribution, an award of the greater of either additional interest or liquidated damages as well as reasonable attorney fees and costs. In addition, the plaintiff asks the court to compel the defendant to submit outstanding remittance reports. When the defendant failed to respond to the complaint, the plaintiff filed a motion for entry of default judgment.

The court finds that the plaintiff's complaint sufficiently alleges facts to support its claim against the defendant. The plaintiff is, therefore, entitled to default judgment as to the defendant's liability for its failure to timely submit remittance reports and pay contributions to the plaintiff. First, pursuant to ERISA, every employer that is obligated to make contributions to a multiemployer plan under the terms of the plan or under the terms of a CBA must make such contributions in accordance with the terms and conditions of such a plan or such an agreement. When an employer fails to make such contributions, ERISA provides that the fiduciary for a plan may bring an action and obtain a mandatory award for the plan consisting of the unpaid contributions, interest on the unpaid contributions, and an amount equal to the greater of interest on the unpaid contributions or liquidated damages provided for under the plan in an amount not in excess of 20% of the amount of the unpaid contributions as determined by the court. In addition, this mandatory award consists of reasonable attorney fees and costs of the action as well as other legal or equitable relief. Interest is calculated using the rate provided under a plan or, if none is provided, the rate prescribed by applicable law.

Here, the court finds that the plaintiff provides the court with affidavits that accurately support a damages award. The plaintiff has sufficiently demonstrated that it is entitled to unpaid contributions; prejudgment interest on unpaid contributions, which is based on an interest rate provided for in the trust agreement; liquidated damages; and attorney fees and costs that the court finds reasonable. Further, the court finds that based on the CBA, the plaintiff demonstrated that it is entitled to the requested equitable relief in the form of an order requiring the defendant to submit all outstanding reports and contributions to the plaintiff.

Accordingly, the court finds that the plaintiff's complaint sufficiently alleges facts to support the claim of unpaid contributions and, therefore, it grants the plaintiff's motion for judgment by default. The court orders the defendant to provide the plaintiff with outstanding remittance reports and corresponding contributions.

Bricklayers & Trowel Trades Int'l Pension Fund v. Crowe Construction Inc., No. 1:22-cv-00047-CKK (D.D.C., July 18, 2023).

CONTRIBUTIONS

Termination of Nonqualified Deferred Compensation Plan Ends Future Payment Obligations

COMPENSATION

The U.S. District Court for the Western District of Michigan grants the plaintiff's motion to dismiss the defendants' counterclaims and motion for judgment on the pleadings because the court finds that the defendants' counterclaims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA) and that the plaintiff properly terminated its obligations to the defendants.

The plaintiff is a former employer of the defendant employees and a plan sponsor of a nonqualified deferred compensation plan originally formed by the plaintiff's predecessor. The defendants are former executives who worked for the plaintiff and its predecessor and are participants in the plan. The plan is governed by ERISA.

The plaintiff decided to terminate the plan under the plan's termination provision. The plaintiff then wrote to the defendants, informing them of the termination and paid the defendants the deferred compensation account balances to which they were entitled. In doing so, the plaintiff claims to have discharged in full its obligations to the defendants. However, the defendants claim that not only were they entitled to deferred compensation after termination, but that their beneficiaries were also entitled to a gratuity upon the defendants' death. As a result, the plaintiff filed suit and seeks a declaration that it properly discharged its obligations when it terminated the plan and paid the defendants.

The plan provides for a lump sum to be paid to a participant's beneficiary, except that no payment is to be made following an event giving rise to the payment of a participant's account balance upon termination of employment. The plan further states that the plaintiff may terminate the plan if the continuation of the plan is not in the best interest of the plaintiff and, upon termination, the plaintiff may discharge in full its obligation to any plan participant upon payment of the participant's account balance.

The defendants bring state law counterclaims for breach of contract, breach of the implied covenant of good faith and fair dealing, and breach of fiduciary duty. In response, the plaintiff moves to dismiss the defendants' counterclaims on the grounds that they are preempted by ERISA, which supersedes state laws as it relates to employee benefit plans, and the phrase *relate to* has a broad meaning such that a state law cause of action is preempted if it has a connection with or reference to that plan.

The court finds that each of the defendants' counterclaims is preempted by ERISA because ERISA specifically provides remedies for breaches of contract and fiduciary duties. Consequently, any state law claim that grants relief for these breaches duplicates, supplements or supplants the ERISA civil remedies. Further, claims for state law breach of the implied covenant of good faith and fair dealing are quasi-contractual claims, and the claims that relate to the plan are preempted by ERISA. Moreover, it is not the label placed on a state law claim that determines whether it is preempted, but whether, in essence, such a claim is for the recovery of an ERISA plan benefit. Consequently, the court finds that because each of the counterclaims requests the amount that the defendants believe they are due under the plan, the defendants' state law counterclaims relate to an ERISA benefit plan and are therefore preempted.

The plaintiff also moves for judgment on the pleadings on its claim for declaratory judgment and seeks a declaration and order that it has properly terminated the plan and that the section of the plan governing payment upon death does not survive the termination. In response, the defendants argue that the plaintiff has not discharged its duty to pay out survival and death benefits to the defendants' beneficiaries under the plan or, in

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Salary Continuation Program Claim Fails Due to Filing Outside of Limitations Period

DISABILITY BENEFITS

The U.S. District Court for the Western District of Texas grants the defendants' motion to dismiss and dismisses the plaintiff's short-term disability (STD) breach of contract claim because the plaintiff brought it outside the contractual limitations period.

The plaintiff is a former employee of the defendant electric company. The defendants include the electric company as the plaintiff's former employer and a third-party administrator that administers the company's salary continuation program for its employees.

The salary continuation program is a payroll practice exempt from the Employee Retirement Income Security Act of 1974 (ERISA). Similar to STD insurance, it is designed to continue a portion of an employee's pay when a medical condition prevents that employee from working. Employees are eligible for the salary continuation program benefits as of their first day of work, and all benefits are considered part of the employee's normal compensation.

To receive the benefits, an employee must be under the care of a doctor whose certification of disability is approved by the defendants, and the defendants must determine that the employee is unable to perform the duties of their job or another job. Employees can also enroll in a long-term disability (LTD) plan. To receive the benefits, an employee must be totally disabled and under a doctor's care for the disability. Employees must pay premiums to enroll in LTD benefits coverage. For employees who receive salary continuation benefits, LTD benefits begin automatically after the salary continuation benefits end. For employees not eligible for salary continuation payments, LTD benefits begin 26 weeks after the onset of the disability.

When the plaintiff was hired, she automatically became eligible for the plan, and she also elected LTD coverage. Later, the plaintiff began experiencing health conditions, and her doctor recommended that the plaintiff stop working. The plaintiff filed a claim for salary continuation benefits, but the defendants denied the claim because they did not receive a statement from the plaintiff's physician certifying her disability. The plaintiff appealed and provided medical records, which were forwarded to a third-party medical reviewer, who found that the provided records lacked sufficient evidence of physical impairment to support her disability claim. The defendants concluded that the plaintiff did not qualify for benefits and denied her appeal. The plaintiff submitted a second and a third appeal but was again denied.

While the plaintiff pursued her salary continuation claim, she also tried to submit a claim under the defendant company's LTD program. The defendants told the plaintiff that she first needed to apply for Social Security Disability Insurance (SSDI) benefits through the Social Security Administration and that the defendants would reopen the salary continuation claim if her SSDI benefits were approved. When the Social Security Administration awarded her disability benefits, the plaintiff attempted to reopen her salary continuation claim and seek LTD benefits. However, the defendants refused to review her salary continuation claim because they determined that she had exhausted her three appeals and that she was not entitled to LTD benefits because she was ineligible for salary continuation benefits.

The plaintiff alleges that the defendants violated the terms of the salary continuation program when they wrongfully denied her benefits and argues that this conduct amounts to a breach of contract. State law provides a default four-year statute of limitations, but parties can contractually agree to a limitation period between two and four years.

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Salary Continuation Program Claim

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The defendants argue that the plaintiff's breach of contract claim for salary continuation benefits is time-barred under the three-year limitations period established in the administrative handbook for the salary continuation benefits. The administrative handbook states that a lawsuit must be filed within three years after the earliest of the date the first benefit payment was allegedly due, the date the benefit was first denied or the earliest date on which the participant knew or should have known of the material facts on which the claim or action is based.

The plaintiff contends that the limitations period in the administrative handbook only applies to lawsuits against ERISA-governed benefits, such as LTD benefits. Because the salary continuation program is ERISA-exempt, the plaintiff argues that it is not subject to the same three-year limitations period but is instead governed by the default four-year period of limitations.

Here, the court agrees with the defendants that the salary continuation program is governed by the administrative handbook. The court finds that the plaintiff overlooks that certain provisions of the administrative handbook state that the claims procedures described in the handbook apply to both the ERISA-governed benefits and the salary continuation program. Thus, the plaintiff's claims for salary continuation benefits are governed by the plain terms of the administrative handbook and are subject to the three-year limitations period. The court finds that the plaintiff did not file a suit until more than three years after the plaintiff's claim accrued on the date the salary continuation benefit was first denied. Therefore, the court rules that the plaintiff's claim for salary continuation benefits is barred by the contractual limitation period.

Accordingly, the court finds that the plaintiff brought her claim outside the contractual limitations period, so the court grants the defendants' motion to dismiss.

Martin v. Sedgwick Claims Management Services, Inc., et al., No. 5:23-cv-00169-XR (W.D.Tex., July 12, 2023).

Nonqualified Deferred Compensation Plan

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the alternative, that survival and death benefits will be due to the defendants' beneficiaries in the future.

The court finds that the defendants are incorrect. The section of the plan governing payment upon death plainly and unambiguously provides that no payment shall be made following the plan termination that gives rise to the payment of a participant's account balance. Because the contractual provisions of an ERISA plan should be enforced as written, the court finds that no payment is owed to the defendants' beneficiaries upon the defendants' deaths. In addition, the court finds that the defendants have waived any further counterarguments by failing to timely respond to the plaintiff's motion.

Accordingly, the court finds that the defendants' counterclaims are preempted by ERISA and that the plaintiff properly terminated its obligations to the defendants under the provisions of the plan, so the court grants the plaintiff's motion to dismiss the defendants' counterclaims and grants the plaintiff's motion for judgment on the pleadings.

Howmet Aerospace, Inc. v. Corrigan et al., No. 1:22-cv-00713 (W.D.Mich., July 14, 2023).

Arbitrator's Award in Withdrawal Liability Action Confirmed

ARBITRATION

The U.S. District Court for the Northern District of Alabama denies the plaintiff's motion for summary judgment, grants the defendant's motion for summary judgment, and confirms the arbitrator's award because the court agrees with the defendant's calculation of withdrawal liability.

The plaintiff is a former contributing employer to a multiemployer pension plan. The defendant is a trust fund for the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff's employees were members of a labor union and, consistent with the collective bargaining agreement, the plaintiff contributed to the plan on behalf of its union employees. Subsequently, the plaintiff stopped offering pension benefits to its union employees, partially withdrew from the plan and later completely withdrew from the plan. Upon the partial withdrawal, the defendant assessed the plaintiff's partial withdrawal liability, and upon the complete withdrawal, the defendant assessed the plaintiff's complete withdrawal liability.

A formula to calculate the withdrawing employer's liability is set by the Multiemployer Pension Plan Amendments Act of 1980 (MPPAA). MPPAA states that after the liability is calculated, four potential adjustments should be applied to reduce the total liability amount. MPPAA also states that where an employer incurs withdrawal liability in successive withdrawals from a plan, the later withdrawal liability is reduced by the earlier withdrawal liability in the form of a partial withdrawal liability credit.

The dispute centers on where in the formula the partial withdrawal liability credit should be applied. In its calculations, the defendant followed the circuit court's precedent and applied the partial withdrawal liability credit as part of the second potential adjustment described in MPPAA. However, the plaintiff insisted that the credit was not one of the adjustments but instead should be applied after all the adjustments. Using the plaintiff's method of calculation would result in a significantly lower withdrawal liability.

Disagreeing with the defendant's calculations, the plaintiff requested arbitration as to the assessments of withdrawal liability. The arbitrator agreed with the defendant that the partial withdrawal liability credit should be applied as part of the second potential adjustment and ordered the plaintiff to pay the assessed withdrawal liabilities for the initial partial withdrawal and the subsequent complete withdrawal. The plaintiff then filed a lawsuit, seeking modification or vacatur of the arbitration award and an order directing the defendant to recalculate the complete withdrawal liability. The defendant counterclaimed, seeking to enforce and confirm the arbitrator's award. Both parties move for summary judgment.

The plaintiff argues that the terms *withdrawal liability, adjustment* and *reduction* have specific meanings in MPPAA that, if used correctly, establish the necessity of applying the credit after all the potential adjustments. The plaintiff also argues that to the extent that MPPAA is ambiguous, the court should defer to the Pension Benefit Guaranty Corporation's (PBGC's) opinion letter and regulations.

The defendant responds that the plain language of MPPAA requires application of the credit as part of the second potential adjustment and that MPPAA does not define *withdrawal liability, adjustment* and *reduction* in the ways the plaintiff asserts. Also, the defendant responds that the PBGC's opinion letter does not warrant any deference because the statute is unambiguous.

The court finds that although the text of MPPAA is not the clearest and the reasoning in a circuit court's case is not persuasive, the partial withdrawal liability credit must nonetheless be applied

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Arbitrator's Award
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as part of the second potential adjustment. In addition, the court finds that the circuit court's decision, which is nonetheless not binding on the court since it comes from another court of appeals, correctly held that the unambiguous words of the statute require application of the credit as part of the second potential adjustment. However, the court finds that the circuit court conducted a textual interpretation of MPPAA based not on the language from the statute but on a Supreme Court decision that is irrelevant in calculating an employer's withdrawal liability. After engaging in statutory interpretation of MPPAA, the court finds that although the relevant provisions of the law are not drafted in the clearest of terms, the canons of statutory interpretation support the defendant's reading of the statute, which indicates that the second adjustment includes a partial withdrawal liability credit.

Furthermore, the court finds that the plaintiff's other arguments are not persuasive. First, the plaintiff argues that the defendant's actuary admitted at the arbitration that it does not make sense to use the previous partial withdrawal liability, which was capped under relevant MPPAA provisions, to calculate a credit that will be applied against the uncapped allocable amount of unfunded vested benefits. The court finds that a witness's opinion about the actuarial sense of a calculation, even if accurate, is not persuasive in interpreting the meaning of a statute. Second, the plaintiff argues that the purpose of the partial withdrawal liability credit is to protect a withdrawing employer from being charged twice for the same unfunded vested benefits of a plan. The court finds that this statement comes from the PBGC, not Congress, but even if the statement could impact the court's interpretation of MPPAA, the plaintiff does not establish that application of the credit before the cap results in charging the plaintiff twice for the same unfunded vested benefits of the plan.

Finally, the plaintiff argues that the relevant MPPAA provisions are ambiguous and the PBGC's regulations and opinion letter are entitled to deference. The court finds that the statute is not ambiguous, and neither the regulation nor the opinion letter would alter the analysis because the regulation does not clarify whether the partial withdrawal liability credit must be applied as part of the second potential adjustment or after all adjustments have been made. The court also finds the PBGC's opinion letter unpersuasive because the plaintiff's only argument about the persuasiveness of the opinion letter is that it is consistent with the text of the statute. But because the court finds that the text of the statute is clear and requires application of the credit as part of the second potential adjustment, the court does not find the PBGC's opinion letter persuasive.

Accordingly, the court finds that MPPAA requires application of the partial withdrawal liability credit as part of the second potential adjustment to the complete withdrawal liability, so the court denies the plaintiff's motion for summary judgment, grants the defendant's motion for summary judgment and confirms the arbitrator's award.

Perfection Bakeries, Inc. v. Retail Wholesale & Dep't Store Int'l Union & Industry Pension Fund, No. 2:22-cv-00573-ACA (N.D. Ala., July 07, 2023).

Washington Update

Guidance on HIPAA and Cybersecurity Authentication

In June 2023, the U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) issued a newsletter on how to "lock the cyber door" to best prevent and deter cyberattacks against electronic protected health information (ePHI). The Health Insurance Portability and Accountability Act (HIPAA) Security Rule requires regulated entities to implement authentication procedures to verify that a person or entity seeking access to ePHI is the one claimed. Regulated entities are covered entities, which include health plans, health care clearinghouses and certain health care providers as well as business associates, which include vendors of covered entities.

Noncompliance with the HIPAA Security Rule and poor authentication practices leave regulated entities vulnerable to cyberattacks and breaches of ePHI. Although the HIPAA Security Rule does not prescribe the implementation of specific implementation solutions, a regulated entity's risk analysis should inform its selection and implementation of authentication solutions that sufficiently reduce the risks to ePHI.

To comply with the HIPAA Security Rule, regulated entities are required to implement authentication solutions of sufficient strength to ensure the confidentiality, integrity and availability of their ePHI. A regulated entity's risk analysis should guide its implementation of authentication solutions to ensure that ePHI is appropriately protected. As a best practice, regulated entities should consider implementing multifactor authentication solutions, including phishing-resistant multifactor authentication, where appropriate, to improve the security of ePHI and best protect their information systems.

Multifactor authentication requires a person to use two or more distinct factors to gain access. The National Institute of Standards and Technology (NIST) identifies three factors of authentication: (1) something you know (e.g., password, PIN); (2) something you have (e.g., smart ID card, security token); and (3) something you are (e.g., fingerprint, facial recognition, other biometric data). Multifactor authentication makes it more difficult for an attacker to gain unauthorized access to information systems, even if an initial factor is compromised.

The Cybersecurity and Infrastructure Security Agency (CISA) recommends that organizations consider implementing multifactor authentication solutions on their internet-facing systems, such as email, remote desktop and VPNs. Also, privileged accounts (e.g., administrator or any account with elevated access rights) or tools that manage privileged access or support a regulated entity's technology infrastructure present risks to ePHI if accessed by unauthorized individuals. Authentication processes controlling access to such accounts and tools should be properly assessed to ensure that the regulated entity's implemented authentication procedures are sufficient to reduce risk.

The newsletter is available at www.hhs.gov/hipaa/for-professionals/security/guidance/cybersecurity-newsletter-june-2023/index.html.

69TH ANNUAL EMPLOYEE BENEFITS CONFERENCE

October 1-4, 2023 | Boston, Massachusetts

1. Attendees enjoy a light-hearted moment before one of the keynote sessions.
2. Chair massages were one of the many perks available at the Hospitality Hub.
3. Monday's keynote session speaker, Hoan Do, a former America Ninja Warrior participant, highlights the value of making connections.
4. Rebecca S. Johnson, co-founder and chief integrator of ViDL Solutions Inc., leads a preconference session "Developing a Leadership Mindset."
5. Sean P. Madix, 2023 International Foundation Board of Directors Chair and President, welcomes attendees during the opening session.

6. A reception for public employees offered an opportunity to network and share experiences.
7. A therapy dog revels in some affection from an attendee during one of the half-hour conference breaks.
8. Dr. Sanjay Gupta, CNN chief medical correspondent and a practicing neurosurgeon, makes a point during the Sunday opening keynote session "Keep Sharp: Build a Better Brain at Any Age."
9. With more than 280 booths, the exhibit hall is an excellent place to explore employee benefits products and services.
10. Small-group discussions are a popular feature of the Trustees Masters Program (TMP).

A Tremendous Thank-You to Our 2023 Sponsors

The International Foundation gratefully acknowledges the following organizations for their sponsorship of our 2023 events.

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For information on sponsorship opportunities in 2024, please contact Diane Mahler at (262) 373-7656 or dianem@ifebp.org.

Thank You, Exhibitors

We Gratefully Acknowledge Our 2023 Exhibiting Organizations

The International Foundation recognizes these organizations for their commitment and contributions to the educational mission of the International Foundation by exhibiting at and supporting our conferences.

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American Century Investments
American Deposit Management
American Realty Advisors
Amplifon Hearing Health Care
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For information on exhibit opportunities, please contact Julie Ichiba at (262) 373-7674 or jichiba@ifebp.org.

member profile

Member of the Moment
David J. MacDonald, M.D.

Serving

Elected trustee for the Contra Costa County Employees' Retirement Association (CCCERA) in Contra Costa County, California. Also serves on the board of directors for the State Association of County Retirement Systems, an association for 20 independent county retirement systems in California.

By Day

"I work for Contra Costa Health Services as a physician. I am a hospitalist and have worked at the county for over 33 years. I am also president of our union—Physicians' and Dentists' Organization of Contra Costa (PDOCC)."

Biggest Reward as a Trustee

"Looking after the security of our members' pensions. This is a great responsibility that I appreciate and take very seriously."

Biggest Challenge

"A challenge taken on with great respect—to learn more and more about solid governance, leadership and asset allocation."

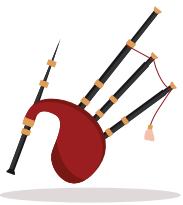
Advice for New Trustees

"Get as much trustee education as you can. It is a steep learning curve. But the investment in time and energy is worth it. Always think of your members—They are who we are here for."

International Foundation Educational Programs Attended

"Part of my early involvement with the Foundation was to go through the Certificate of Achievement in Public Plan Policy (CAPPP®) programs. This gave me a better foundation in becoming a responsible and more effective trustee. Subsequently, I went through the Trustees Masters Program (TMP), and I regularly attend the Annual Employee Benefits Conference and Washington Legislative Update as well as others."

In My Spare Time



"I love Celtic music and play the bagpipes. I am a coffee roaster, and my folks and I have a small coffee roastery in Oregon. I love traveling to Scotland and Ireland. Being around family and friends is a very important and enriching part of life."

plan | ahead

November 2023

6-7 Collection Procedures Institute
Santa Monica, California
www.**ifebp.org**/collections

6-10 Essentials of Multiemployer Trust Fund Administration
Santa Monica, California
www.**ifebp.org**/essentialsme

January 2024

21 Institute for Apprenticeship, Training and Education Programs—Preconference
Las Vegas, Nevada

22-24 Institute for Apprenticeship, Training and Education Programs
Las Vegas, Nevada
Virtual option available
www.**ifebp.org**/apprenticeshipinstitute

25-26 Construction Industry Benefits Conference
Las Vegas, Nevada
www.**ifebp.org**/construction

29 33rd Annual Health Benefits Conference and Expo—Preconference
Clearwater Beach, Florida

30-31 33rd Annual Health Benefits Conference and Expo (HBCE)
Clearwater Beach, Florida
www.**ifebp.org**/hbce

February 2024

10-11 Trustees Institute—Level II: Concepts in Practice
Orlando, Florida
www.**ifebp.org**/trusteeslevel2

11 Trustees and Administrators Institutes—Preconference
Orlando, Florida

12-14 New Trustees Institute—Level I: Core Concepts
Orlando, Florida
www.**ifebp.org**/newtrustees

12-14 Advanced Trustees and Administrators Institute
Orlando, Florida
www.**ifebp.org**/trusteesadministrators

19-23 Certificate in Global Benefits Management
Austin, Texas
www.**ifebp.org**/globalcertificate

March 2024

3 Health Care Management Conference—Preconference
Rancho Mirage, California

4-5 Health Care Management Conference
Rancho Mirage, California
www.**ifebp.org**/healthcare

4-9 Certificate Series
Scottsdale, Arizona
www.**ifebp.org**/certificateseries

6-7 Investments Institute
Rancho Mirage, California
www.**ifebp.org**/investments

April 2024

8-9 34th Annual Art & Science of Health Promotion Conference—Preconference
Hilton Head Island, South Carolina

10-12 34th Annual Art & Science of Health Promotion Conference
Hilton Head Island, South Carolina
www.**ifebp.org**/healthpromotionconference

May 2024

6-7 Washington Legislative Update
Washington, D.C.
www.**ifebp.org**/washington

June 2024

22-23 Trustees Institute—Level II: Concepts in Practice
Las Vegas, Nevada

23 Trustees and Administrators Institutes—Preconference
Las Vegas, Nevada

24-26 Advanced Trustees and Administrators Institute
Las Vegas, Nevada

24-26 New Trustees Institute—Level I: Core Concepts
Las Vegas, Nevada

24-26 Accounting and Auditing Institute for Employee Benefit Plans
Las Vegas, Nevada
Virtual option available
www.**ifebp.org**/accountants

24-28 Essentials of Multiemployer Trust Fund Administration
Las Vegas, Nevada

[schedule subject to change]

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

benefit fringe

foundation gift supports life-saving services

Providing education on mental health and addiction issues continues to be a priority for the International Foundation of Employee Benefit Plans. But the Foundation's commitment to removing stigma and improving outcomes related to mental health extends beyond programming to include financial support.

In October, during the 69th Annual Employee Benefits Conference in Boston, Massachusetts, International Foundation Chief Executive Officer Terry Davidson, CEBS, announced a $15,000 donation to Samaritans, Inc., a Boston-based nonprofit organization. The contribution is in keeping with the Foundation's tradition of making a donation to local organizations in the conference host community.

"For nearly 50 years, Samaritans has provided Massachusetts with life-saving suicide prevention services as well as hope and support to those affected by suicide," Davidson said.

Samaritans offers the following free, confidential, compassionate and nonjudgmental services.

- A 24/7 helpline, offering people in crisis support by phone or text from a caring listener who is part of their team of trained volunteers
- Suicide prevention and awareness workshops, including free virtual or in-person workshops for local schools, community organizations and workplaces
- A peer-to-peer support texting service for young people
- Grief support for suicide loss survivors

In 2022 alone, the organization reached more than 8,000 people, offered grief support to over 1,500 people and answered more than 81,000 phone calls.

"Our donation will support their Community Education and Outreach program, which provides free workshops on how to recognize warning signs of suicide for workplaces and other organizations. The International Foundation is pleased to support their important work and mission," Davidson said.

"Samaritans is so pleased to be recognized by the International Foundation of Employee Benefit Plans," said Kathleen C. Marchi, Samaritans chief executive officer and president. "Employers play an important role in preventing suicide by offering education and wellness programing for employees. Samaritans will use this generous contribution to continue our work presenting suicide prevention workshops to corporations and employers, large and small."

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Learn more at www.cebs.org.

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Academic Partners: Wharton University of Pennsylvania

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- Ventura County's Successful Transition to a Virtual Wellness Program
- Diabetes and Obesity Risk Management Strategies for Health Plans
- Finding Common Ground: Navigating Inclusion and Diversity in a Polarized Environment
- Staff Networking Groups—A Novel Approach to Employee Feedback
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January 29-31, 2024
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