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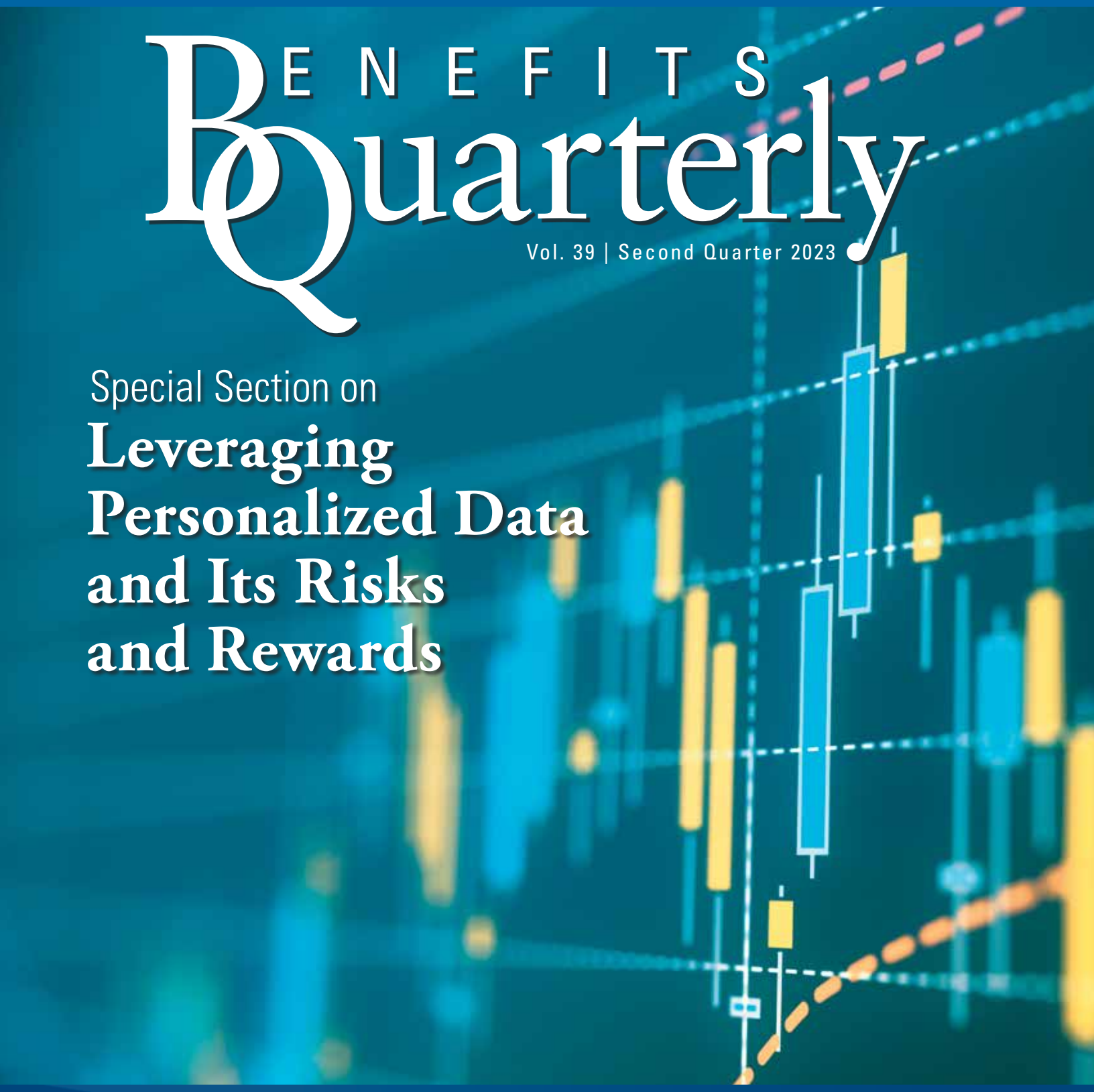

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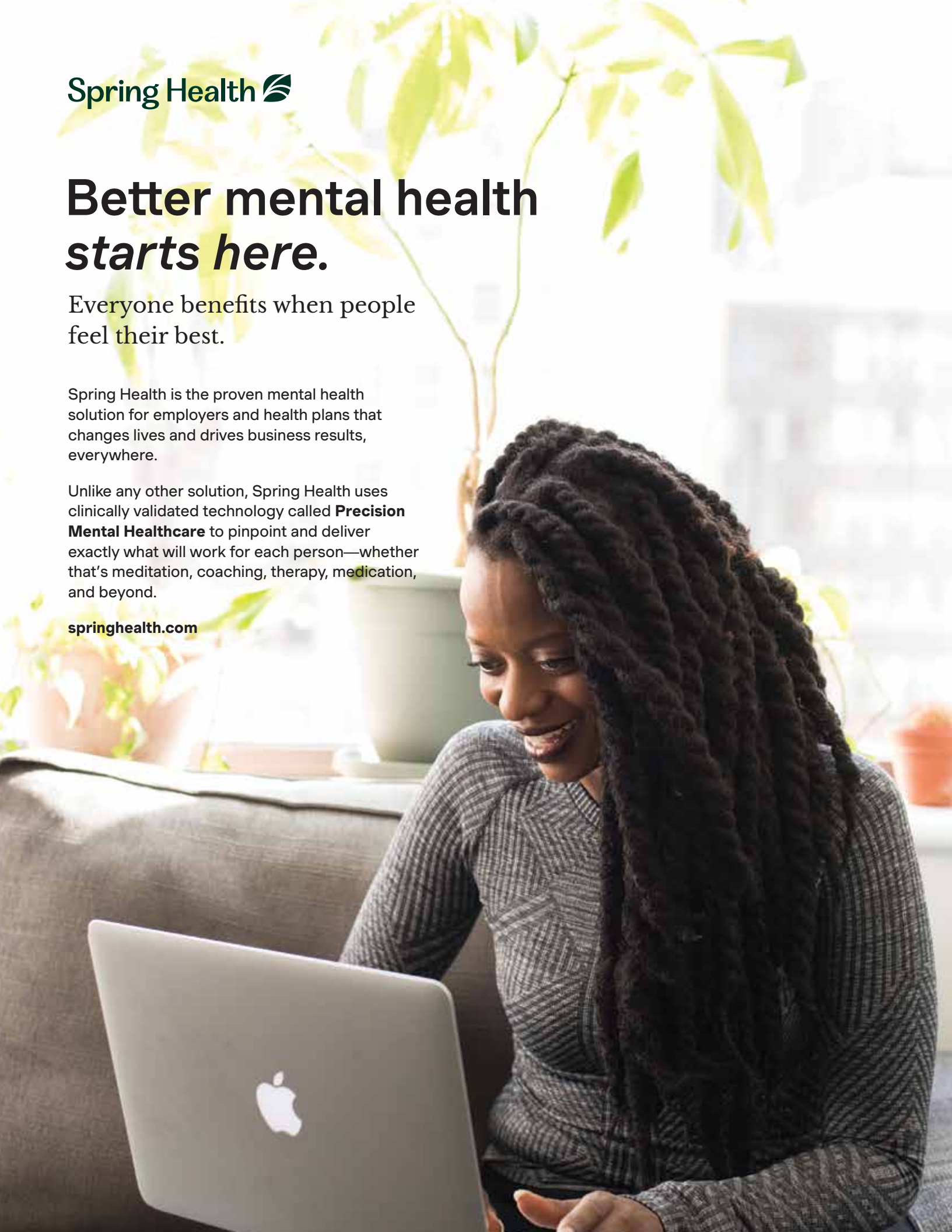

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behind the scenes

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executive summaries

Promoting Health Equity by Making Better Use of Race and Ethnicity Data

by **Bowen Garrett, Ph.D.** | *Urban Institute*
Ilyse Schumann | *American Benefits Council*
Jennifer M. Haley | *Urban Institute*
Lisa Dubay, Ph.D. | *Urban Institute*

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As sponsors of health insurance coverage for more than half the U.S. population, employers can play a unique role in efforts to understand and address health inequities. But lack of complete and consistent data on enrollees' race and ethnicity can inhibit progress. Recent research explored barriers and solutions to improving the use of such data for advancing health equity. Recommendations for employers include prioritizing and clarifying the value of data collection. Federal government partnership is also needed, including guidance to clarify the permissibility of such efforts. Finally, measuring and understanding health disparities must be followed by accountability and interventions to close equity gaps. The COVID-19 pandemic has highlighted not only the extent of health inequities in the population but the shared obligation that multiple sectors—including employers—have in addressing them.

Understanding Today's High-Cost Participants Through Data Analytics

by **Sadhna Paralkar, M.D.** | *Segal*
Jason Jossie | *Segal*
Eric Miller | *Segal*

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One of the greatest challenges plan sponsors face is budgeting for increasingly volatile health care expenses. Higher prevalence of chronic conditions alongside new technologies and treatments mean that high-cost events are becoming more common. Perpetually increasing health care costs and increasing population morbidity can make it difficult to determine whether intervention efforts are having a positive effect on plan participants, and the vast array of management programs available can be confusing for plan sponsors to navigate with limited resources. Advancements in data analytics allow plan sponsors to better understand these high-cost participants, including the impacts of environmental and social factors on their physical and mental health. Leveraging data analytics, plan sponsors have greater and more current insights into what conditions and disease progressions are common among high-cost participants. Plan sponsors have more tools at their disposal than ever to understand how to allocate limited resources and develop the most effective strategies to help mitigate the impact of these high-cost events, allowing them to continue to offer competitive benefits and improving plan participants' lives in the process.

My QDIA Is Better Than Your QDIA

by **Jack M. Towarnicky, CEBS**
Of Counsel, Koehler Fitzgerald, LLC

p23

My 401(k) plan's investment fiduciary committee implemented target-date models (TDMs) as our qualified default investment alternative (QDIA) in March 2006. Since then, a few plans have taken similar action. An update to a new release, Model 2.0, would ensure that a TDM will remain the 21st century best-in-class QDIA—especially if investment fiduciaries decide to add "guaranteed retirement income" features. If you are using a well-known 401(k) or 403(b) service provider/recordkeeper, they probably have already implemented all the systems and processing functionalities that are needed to implement/administer TDMs as your QDIA.

Using Lessons From COVID-19 Vaccine Hesitancy to Increase Retirement Plan Participation

by **Barbara A. Smith, Ph.D.** | *Pension Policy Center*
John A. Turner, Ph.D. | *Pension Policy Center*
Kamila Bielawska, Ph.D. | *University of Gdansk*

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Vaccines and employer-provided pensions are two examples of *merit goods*—goods that policy makers think people should consume. A major policy puzzle has been the refusal of many people in the United States to get vaccinated to protect themselves and others against COVID-19, even when the vaccines are free. Similarly, many workers do not sign up for retirement plans offered by their employers with matching contributions despite the important contribution these plans would make to their retirement income security. This article investigates the findings of research into vaccine hesitancy for insights and approaches applicable to overcoming resistance to participating in retirement plans. It concludes with suggestions for encouraging greater uptake among those with access to retirement plans.

Democratizing Health Care: Providing Equal Access to Quality Care for All Covered Members

by **Dana Baker** | *Mayo Clinic Complex Care Program*
Cheryl Nienhuis, CEBS | *Mayo Clinic Complex Care Program*
Brent Westra | *Mayo Clinic Complex Care Program*

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One-fifth of all health care dollars are spent caring for people with complex medical conditions. Yet medically complex individuals account for just 1% of patients. These same individuals are often forced to miss work due to less-than-adequate care for their conditions, resulting in loss of productivity and increased costs to employers. Providing equal access to quality care for complex conditions can improve health outcomes and cap costs for employees as well as lead to long-term cost savings and lower absenteeism for employers. This article focuses on barriers to accessing complex care, the health and financial implications of getting it wrong, and how benefit managers—in partnership with payers, providers and other vendors—can ensure equal access to quality care for all.

Promoting Health Equity by Making Better Use of Race and Ethnicity Data

by **Bowen Garrett, Ph.D.** | *Urban Institute,* **Ilyse Schumann** | *American Benefits Council,* **Jennifer M. Haley** | *Urban Institute* and **Lisa Dubay, Ph.D.** | *Urban Institute*

The COVID-19 pandemic shined a light on disparities in health care treatment and outcomes by race and ethnicity (R/E) that have been well-documented for decades. While the Institute of Medicine released its landmark report *Unequal Treatment* 20 years ago, the pandemic drew broader attention to the human and financial costs of not addressing racial and ethnic disparities in health care (Institute of Medicine, 2003).

Given their critical role in the health care system, employers have an important part to play in efforts to promote health equity. Employers provide health coverage to approximately 177 million people in the United States.[1] Covering 54% of the U.S. population, employer-sponsored health insurance is the predominant source of health insurance in the country, eclipsing Medicare and Medicaid, which each cover about 18% of Americans. In 2020, private health insurance spending (including the group and individual markets) totaled $1.15 trillion, or 28% of overall U.S. health care spending, making private insurance the largest source of health care spending—ahead of Medicare, which accounts for 20%.[2]

While momentum to advance health equity is building, incomplete and inconsistent data on individuals' R/E that can be used to assess and address disparities in health outcomes impede the efforts of employers and their group health plans to achieve greater equity in health care. Recognizing that data collection and use is the foundation of advancing health equity, the Urban Institute, the American Benefits Council and the Deloitte Health Equity Institute embarked on a project, supported by Elevance Health, to closely examine the barriers to R/E data collection and identify recommendations for improvement (Haley et al., 2022).[3] This article focuses on two aspects of the research and recommendations from the study that are particularly

AT A GLANCE

- Employers can play a unique role in efforts to understand and address health inequities, though lack of complete and consistent data on enrollees' race and ethnicity (R/E) inhibits progress.
- Recent research explored barriers and solutions to improving the use of such data for advancing health equity, finding that better communication of its value could spur action.
- Many employers perceive legal barriers to sharing employee R/E data with health plans, but a legal analysis found that no federal law prohibits employers and group health plans from sharing data for the purpose of reducing disparities.

critical to employers and employer-sponsored group health plans. The first explores the value to employers of R/E data collection to advance health equity, concluding that better communication of the value of improved data collection and sharing could help encourage action. The second examines the actual and perceived legal concerns and uncertainty regarding employers and group health plans collecting and sharing such data, recommending that relevant federal agencies develop guidance about the ability of employers to share R/E data with health plans.

Employer-Sponsored Group Plans Are Uniquely Positioned to Use R/E Data to Advance Health Equity

Employers have a vested interest in securing the health and well-being of their workers. U.S. businesses recognize that helping all employees thrive has a measurable impact on virtually every aspect of their business, and they are leveraging purchasing power, market efficiencies and plan design innovations to that end. When commitment to employees as well as diversity, equity and inclusion (DEI) is coupled with the drive for innovation and value, employers can play an essential role in harnessing R/E data to identify and reduce health care inequities.

R/E Data in the Commercial Insurance Market Are Inconsistent and Incomplete

Despite limitations in accuracy, consistency and comparability, R/E data are relatively complete for enrollees in the two major public insurance programs in the U.S—Medicare and Medicaid (Grantmakers in Health, 2021; Grafova and Jarrín, 2020; Melendez et al., 2022; Ng et al., 2017). Less is known about the extent of data collection for commercial coverage. Self-reported data are the ideal, and there was broad agreement by study participants that health plan members should not be required to provide R/E data but, rather, reporting should remain voluntary. R/E data may be collected by providers in electronic health records or by employers, for those with employer-based coverage. But these data are seldom shared across health systems or with health plans. One large payer told researchers that only a quarter of its commercial population had complete R/E data, and these were mainly collected through electronic medical records, labs, enrollment forms and immunization registry data.

How Better R/E Data Can Advance Health Equity

A number of recent studies point out that better R/E data are needed to identify health inequities and design meaningful strategies to advance health equity—but also that gaps in data completeness and accuracy have long hindered such efforts (Grantmakers In Health, 2021; McAvey and Reginal, 2021; National Commission to Transform Public Health Data Systems et al., 2021).

One key finding from the research was that a lack of understanding and communication of the value of improved R/E data collection has been a barrier to progress. To that end, researchers sought to clarify the value that improved data collection holds for constituent groups, including employers. As study participants pointed out, showing the feasibility and value of data collection in reducing disparities could help encourage cultural shifts within organizations toward data collection.

Employer-sponsored health plans, as well as other public and private health plans and payers, often have the most comprehensive view of a person's health insurance data. Linking this information to R/E data allows for tracking of how health outcomes and access to high-quality care differ across racial and ethnic groups as well as how these differences vary geographically and over time. Health plans could then compute a range of quality and equity measures that capture disparities in health care access, clinical outcomes, and enrollee engagement and satisfaction with their plan and providers. An employer plan sponsor could use such measures to hold health plans and integrated health systems accountable for delivering high-quality care for everyone. Health plans and sponsors could also use such information to identify where additional health care resources are needed. They could implement tailored interventions aimed at improving equity and overall quality or adjust their provider networks to include providers best able to meet a community's health care needs.

With more visibility into how well employee health care needs are being met and which employees' needs may be going unmet, employers could ensure a healthier and more productive workforce. If organizations had access to more complete R/E data, combined with other employee information, they could then better address employee challenges and

needs to gain a better understanding of the people they cover. Without data granularity, for instance, an employer might assume common conditions like diabetes and musculoskeletal disorders are equally distributed across its employee population. But with better R/E data, according to a study participant, the company could target solutions to different audiences differently.

With better information at hand, employers would be better equipped to hold health plans and third-party administrators accountable for meeting all employees' health needs equitably and with high quality. Similarly, the health plans would benefit from improved member experiences, better clinical outcomes and improved capacity to reward providers that deliver high-quality care and improve outcomes for all members. Through the payment arrangements they make with providers for furnishing health care services to members, commercial health plans can pursue value-based payment models that create incentives for health care providers to reduce health disparities by tying payments to health equity and quality.

Legal Barriers Around Employers Sharing R/E Data With Health Plans Are Often More Perceived Than Real

Many employers already have R/E data for their employees. Employers collect these data with their employees' consent—often during onboarding—for specific internal purposes and reporting requirements under federal nondiscrimination laws. With about half of the U.S. population covered by employer-based insurance, employers are a major potential source of R/E data on health plan enrollees.

A legal analysis conducted as part of the project did not identify state or federal laws that prohibit employers from collecting and sharing R/E data with group health plans, third-party administrators or group health plan insurers for a permitted purpose, such as reducing health care disparities (Haley et al., 2022, appendix). According to the legal analysis, with regard to the federal landscape:

- No federal law was found that prohibits the collection, storage, use or disclosure of R/E data by group health insurance plans (whether insured or self-funded) for a permitted purpose.
- No federal statute prohibits employers from sharing R/E data for other purposes with group health plans, insurers or third-party administrators.

The state-level landscape is more varied. For self-insured group plans, state laws generally will not apply. For insured group health plans, state laws generally apply and could pose a legal barrier in particular circumstances. (See the legal analysis in Haley et al., 2022, for details.)

Perceived Legal Barriers Limit Data Sharing

Despite the lack of state or federal laws that prohibit it, some employers expressed concerns about sharing R/E data with health plans or other entities because of the unclear legality of doing so under current laws and because of existing employee data consent contracts (in which employers did not indicate they would share such data when employees provided them).

To gain additional insight on employers' collection of R/E data and practices and perceptions about data sharing, the American Benefits Council conducted an informal survey of large employers across the country in April 2022 as part of the project.[4]

- Among the 44 employer respondents, 26 (57%) currently collect R/E data in their capacity as employers.
- Among 22 respondents that collect R/E data and provided details about their sharing, 15 (68%) indicated they do not share the data with anyone. The most commonly cited reason for not sharing the data was "perceived/presumed" legal barriers. Eleven of the 15 employers indicated that "understanding the health plan's intended use of this data" would be a prerequisite for sharing their data with plans.
- Among 12 organizations that do not collect R/E data, six indicated "perceived/presumed legal barriers" as a reason for not collecting the data. Six cited "expected employee hesitancy/reluctance" and five cited "concerns about potential litigation."

Various stakeholders said during the study that eliminating misconceptions about legal barriers is critical to encouraging more data sharing by employers. Uncertainty about whether laws exist that prohibit collecting R/E data, especially at the state level, adversely affects the collection and

use of such data by group health plans and group health insurance issuers. Guidance from appropriate federal agencies could clarify the permissibility of R/E data collection and sharing. Such direction could clarify the preemption of state laws, specify what data uses are allowed and not allowed, and what confidentiality safeguards need to be in place as well as reinforce that employee self-reporting is voluntary. Study participants suggested that the Equal Employment Opportunity Commission and the U.S. Department of Health and Human Services should work together to develop guidance about the ability of employers, providers and community partners to share R/E data with health plans.

Progress Requires Addressing Other Concerns as Well

Though legal clarity would help, it may not be sufficient to fully overcome employer hesitancy about data sharing. Questions about potential liability and accountability would remain. For example, employers may have concerns about possible risks if an analysis were to reveal inadvertent disparities in benefit provisions for certain groups. Employee concerns about potential privacy and data breaches would also continue to be an issue. An understanding of how employees feel about employers sharing R/E data with health plans and third-party insurers is needed. Depending on employee preferences, the sharing of data may result in fewer people reporting their R/E to their employers. The study report discusses these additional barriers, issues of trust and trustworthiness, and lack of updated standards regarding collection of R/E data and proposed solutions. Finally, even committed employers that are eager to make progress in this area will need to prioritize organizational capacity and provide sufficient resources to collect, analyze, share and use R/E data.

Momentum for Multisector Action Using R/E Data to Address Health Inequities Is Strong

At a public event[5] releasing the research, participants highlighted the importance of efforts to use R/E data to address health equity. Stakeholders agreed that health inequities are a "shared problem," creating a "shared obligation for all of us" to work together across sectors to improve data collection and use. Thus, the time is ripe for employers to join other sectors, including government, as partners on this essential work and also to ensure that guardrails are in place to protect employee privacy.

Conclusion

Improved availability of high-quality, complete R/E data opens a range of opportunities to detect and track health equity gaps and evaluate efforts to close them. Sharing such data with health plans for the purpose of reducing disparities is one way that employers can advance health equity. Better data would allow employers to make more informed decisions about the health plans that cover their employees and the health care providers who treat them and to ensure that benefits are addressing the needs of underserved groups of employees. A detailed legal summary of applicable federal and state laws can help reduce concerns about data collection and sharing, as would stronger signals from the federal government to clarify the legality of data collection and sharing with private health plans.

Despite the many opportunities and momentum for improved data collection in which employers can play a major part, many stakeholders contacted during the project emphasized that data collection alone will not eliminate health disparities. Such efforts need to be matched by interventions and the will to make improvements to health care delivery and access to advance health equity and overall quality. These efforts will likely be most successful with employee and community engagement to identify needed improvements and solutions. BQ

Endnotes

1. U.S. Census Bureau, Table HHI-02, "Health Insurance Coverage Status and Type of Coverage—All Persons by Age and Sex: 2017 to 2020," in Current Population Survey Annual Social and Economic Supplement, October 2021.

2. Centers for Medicare & Medicaid Services, "National Health Expenditure Accounts—National Health Expenditures by Type of Expenditure and Program," December 2021. National Health Expenditures 2020 Highlights (cms.gov).

3. The authors are grateful to our research partners and the many participants involved in conducting the project and report we draw from for this article (see Haley et al., 2022). The views expressed in this article are those of the authors and should not be attributed to the Urban Institute, its trustees or its funders. Funders do not determine research findings or the insights and recommendations of Urban Institute experts. Further informa-

tion on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

4. www.americanbenefitscouncil.org/pub/76DBABAB-1866-DAAC-99FB-E21FB5CDA4DE.

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Data and High-Cost Health Plan Participants

Data analytics can be a valuable tool in helping health plan sponsors reduce and mitigate the impact of high-cost claimants. In their article "Understanding Today's High-Cost Participants Through Data Analytics" on page 14, authors Sadhna Paralkar, M.D., Jason Jossie and Eric Miller explain that high-cost participants typically make up less than 1% of plan participants but account for 30% of total spending. They review what data shows about the characteristics of high-cost participants and suggest data-driven strategies for managing high-cost claimants. Highlights include the following.

High-Cost Claimants

56% have one of the following underlying health conditions.

- Diabetes
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Hypertension
- Coronary artery disease (CAD)

24% have cancers.

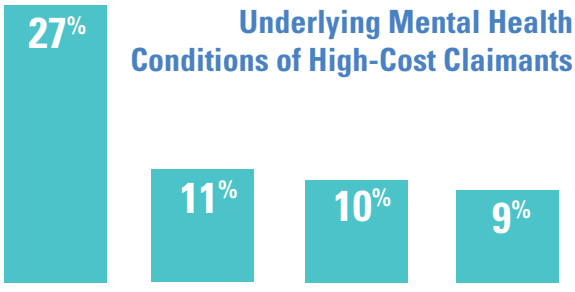
20% have no conditions.

Prevalence of Mental Health Conditions Among Health Plan Claimants

56% High-cost claimants

37% Non-high-cost claimants

Underlying Mental Health Conditions of High-Cost Claimants



Initiatives for Managing High-Cost Claimants

- Develop a data-driven strategy
- Focus on preventing and managing chronic diseases
- Implement intensive medical/ case management
- Establish centers of excellence (COEs) and bundled payment programs
- Manage prescription drug utilization
- Consider a stop-loss policy

Understanding Today's High-Cost Participants Through Data Analytics

by **Sadhna Paralkar, M.D.** | *Segal,* **Jason Jossie** | *Segal* and **Eric Miller** | *Segal*

Health care costs have increased twice as fast as workers' wages over the last decade, according to the *American Journal of Managed Care.*[1] Although the COVID-19 pandemic resulted in a reprieve from health care cost increases for most plan sponsors, there are clear indications that the long-term trend will continue unabated.

The situation for plan sponsors is complicated by the increasing share of total cost represented by high-cost participants whose total medical and drug costs exceed $100,000. These participants typically make up less than 1% of plan participants but account for nearly 30% of total spending. Managing expense for high-cost participants and predicting future costs present unique challenges because this spending is extremely volatile.

Drawing on information from a large database[2] of plan participants, this article will provide insight into the following.

- Who these participants are today
- Who may become high-cost participants
- What strategies may be available to help prevent or mitigate costs, improve population health and reduce volatility within plan budgets

Not all high-cost events are unpredictable "lightning strikes." Plan sponsors can take actions to reduce or mitigate the costs of these events. The more plan sponsors understand the general characteristics and cost drivers, the better they can align interventions and apply viable management strategies.

Table I summarizes the top five primary diagnoses for high-cost (between $100,000 and $1.0 million) and ultra-high-cost ($1.0 million and above) claims for 2018 and 2019 (i.e., prepandemic) compared with 2020 and 2021 (i.e., pandemic).

AT A GLANCE

- Less than 1% of plan participants account for almost 30% of health care spending. High-cost claimants are the leading cause of volatility in health care expenses, an ever-increasing challenge to setting and meeting plan sponsor budgets.
- Data shows that the majority of high-cost claimants are on the radar prior to the primary high-cost event, often following a progression of increasingly severe disease comorbidities.
- Data analytics and population health management strategies can lower the risk and mitigate the costs related to high-cost participants.
- Understanding the underlying health of a population as well as the types of conditions and services driving high-cost care is the first step in developing upstream intervention strategies to prevent future high-cost events.

TABLE I

How Prepandemic and Pandemic High-Cost and Ultra-High-Cost Claims Compare

	High-Cost ($100,000 to $1.0 Million)		Ultra-High-Cost ($1.0 million+)	
Rank	Prepandemic	Pandemic	Prepandemic	Pandemic
1	Spondylopathies	Septicemia	Leukemia	Chronic kidney disease
2	Breast cancer	Spondylopathies	Chronic kidney disease	Septicemia
3	Chronic kidney disease	Breast cancer	Neonatal/births	Leukemia
4	Septicemia	Chronic kidney disease	Cardiac and circulatory congenital anomalies	Neonatal/ births
5	Coronary athero-sclerosis and other heart disease	COVID-19	Septicemia	COVID-19

Source: Segal's SHAPE data warehouse.

The COVID-19 pandemic caused some noticeable shifts among these top diagnoses. For example, it likely contributed to the increase in septicemia and also was the primary diagnosis on high-cost events (mostly intensive care unit (ICU) admissions). Some of the other top diagnoses are fairly intuitive and well-publicized: leukemia, neonatal/births (neonatal intensive care unit (NICU) babies) and heart-related conditions. However, there may be less awareness of the cost significance and general frequency of diagnoses like kidney disease or *spondylopathy* (a term for various forms of arthritis often requiring surgery—particularly spine surgery). This data highlights how important it is to keep a consistent, data-driven focus on the top 1% of plan participants.

Types of Care Driving High-Cost Claims

Over time, several factors may contribute to the prevalence of high-cost events. Some will create upward pressure, such as an aging population, the increasing prevalence of chronic conditions, costly new treatments and technology as well as new high-cost drugs being brought to market. However, it is also important to consider developments that apply downward pressure, like improvements and efficiencies in musculoskeletal surgery resulting in fewer high-cost claims. Many of these surgeries have been transitioning out of the inpatient hospital setting and into the outpatient hospital setting or ambulatory surgical centers. This shift has typically resulted in lower costs without an increased risk of complications. Other developments may result in high costs in the near term yet have potential to create long-term savings and improved quality of life. Examples include some new gene therapies as well as improvements in cancer treatment like precision oncology, targeted immunotherapy and chemotherapy.

As shown in Figure 1, a majority of all expenses associated with high-cost claimants in 2018 were medical costs. Of the remainder, 19% were prescription drug costs covered under the medical benefit (typically drugs for chemotherapy, multiple sclerosis and autoimmune diseases), and 13% were prescription drug costs covered under the pharmacy benefit. By 2021, only 63% of expenses associated with high-cost claimants were medical, as prescription drug costs covered under the pharmacy benefit rose to 18% of the total costs.

The main driver behind this trend is drugs used to treat psoriasis, namely Stelara®, Cosentyx® and Taltz®. These drugs often come with an annual price tag exceeding $100,000 per participant. This trend is expected to continue as other new drugs—that can come with hefty price tags but promise improved quality of life—enter the market. As prescription drugs take up a larger portion of the treatment spectrum, it's becoming increasingly important to ensure that participants are being directed to appropriate sites of care for drug infusions and injections as well as to monitor pharmacy benefit manager (PBM) contracts. PBM contracts should be renegotiated every three to five years to ensure competitive pricing and rebates.

Demographics

It's likely no surprise that the greatest demographic risk factor is age, although it should be noted that high-risk newborns are typically responsible for 2-4% of high-cost claimants and 5-10% of ultra-high-cost claimants. Once a participant reaches age one, the risk of a high-cost claim event significantly decreases and follows a more predictable increasing pattern. Females tend to have greater risk of a high-cost event during the reproductive years, and males tend to have greater risk of a high-cost event in older age ranges, as shown in Figure 2.

Underlying Health Conditions

While correlations between demographics and high-cost claims are interesting, it's more important for plan sponsors to understand the role of underlying chronic conditions and the progression of comorbidities in those claims because that information is actionable.

This analysis focuses on five common, progressive, chronic health conditions:

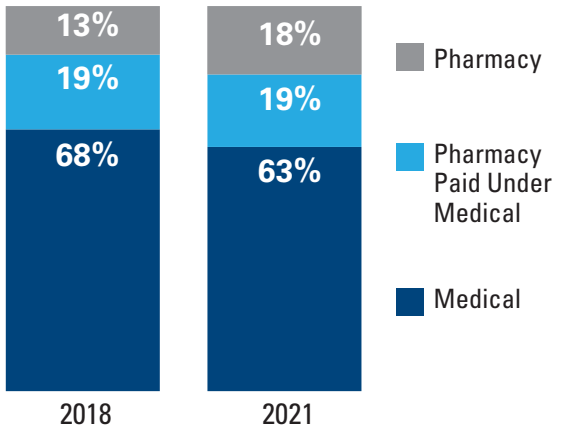
1. Diabetes
2. Hypertension
3. Chronic obstructive pulmonary disease (COPD)
4. Congestive heart failure (CHF)
5. Coronary artery disease (CAD).

Of all high-cost claimants analyzed, more than half had one or more of these underlying conditions, nearly one-quarter were due to cancer and only 20% had neither cancer nor one of these five conditions (Figure 3).

While these are not the ultra-high-cost ($1 million and higher) cases, the good news from a cost-management perspective is that each of these chronic health conditions has

FIGURE 1

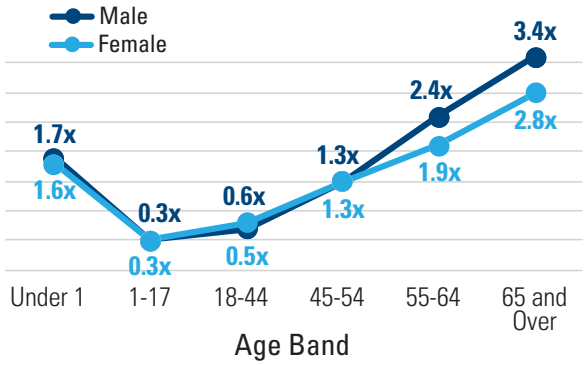
Cost Distribution of High-Cost Claimants



Source: Segal's SHAPE data warehouse.

FIGURE 2

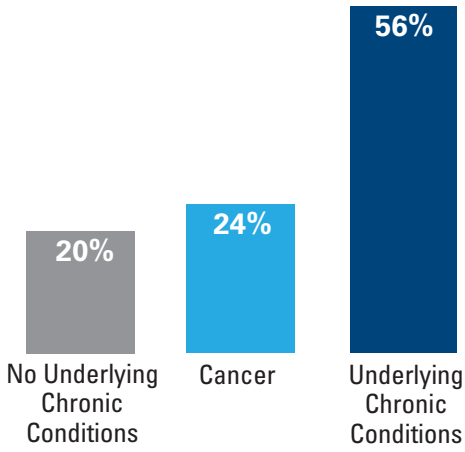
High-Cost Claims Risk by Gender and Age Bands



Source: Segal's SHAPE data warehouse.

FIGURE 3

Underlying Health of High-Cost Claimants



Source: Segal's SHAPE data warehouse.

well-established lifestyle components. That means there is potential to improve long-term health and manage the risk with a combination of physician-guided lifestyle habits and sound (and often less acute) medical treatment. Of course, not all potential high-cost events are preventable, and it's not possible to be certain which individuals will have high-cost claims based on any particular set of factors.

Significantly, few people are entirely off the radar prior to incurring high-cost claims. Many experience a progression of worsening health that is at least to some extent influenced by lifestyle habits (i.e., poor diet, lack of exercise, poor sleep, smoking and drinking) and a pattern of avoiding medical care. A common progression is obesity, eventually leading to hypertension, high cholesterol and/or diabetes before ultimately leading to heart disease (CHF and CAD) and, as we saw during the pandemic, increased susceptibility to the worst potential outcomes of contagions or disease more generally.

In terms of cost, obesity on its own (meaning that it has not progressed to anything more severe) is not particularly costly. Individuals with this condition alone were below average for high-cost claims risk (0.6 times the rate of the average plan participant). However, when either diabetes or hypertension is also present, the high-cost risk increases to 1.5 times that of an average participant. When all three conditions are present, the risk increases to 2.1 times the average. By the time an individual develops heart disease, they have become nine times more at risk of a high-cost event than the average plan participant (Figure 4).

Clearly, the earlier a plan participant's behavior can be influenced—whether that's healthier lifestyle choices, routine engagement with their primary care physician and/or better adherence to recommended treatment—the better their long-term prognosis and the lower their risk of becoming a future high-cost plan participant.

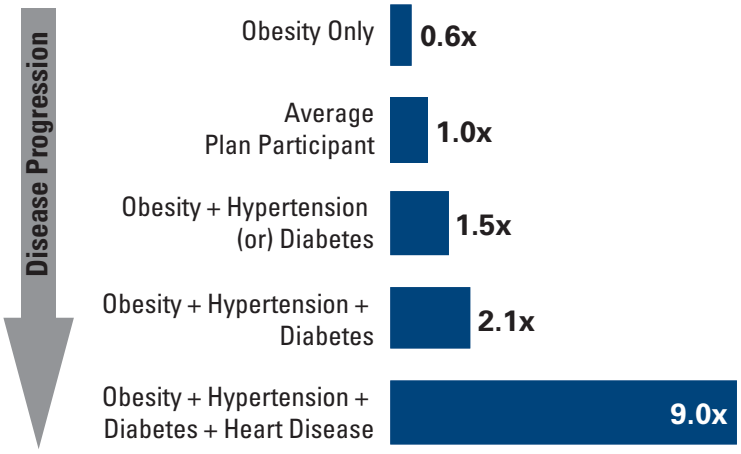
Early diagnosis and treatment can also have a positive impact when it comes to cancer, which, as noted, is related to nearly a quarter of high-cost plan participants. Cancer treatment is possibly the largest component of medical pharmacy spend, which has ballooned over the past decade and makes up an ever-increasing share of overall hospital revenue. The range of treatment costs for a given cancer diagnosis can be very broad since it depends on a variety of highly variable factors. Strategies for limiting the impact of cancer claims and improving diagnoses for participants should begin with improving compliance with recommended cancer screenings. As shown in Figure 5, of all the cancers leading to high-cost events, 42% can be detected early through recommended screenings. These include breast, cervical, colorectal, lung, prostate and skin cancer.

The Mental Health Component

While physical conditions dominate the discussion on high-cost claimants, a mental health comorbidity has become increasingly common among high-cost participants. There is also some correlation between mental health and the risk of having a catastrophic event and/or suboptimal recovery after a catastrophic event.

FIGURE 4

Disease Progression and High-Cost Claims Risk



Source: Segal's SHAPE data warehouse.

This is not to say that conditions like depression and anxiety necessarily *cause* worse outcomes, as sometimes they are a direct *result* of worse outcomes. However, evidence exists to make us consider the effect and at least to reject the idea that high-cost events are entirely derived from the physical prognosis.

According to the data illustrated in Figure 6:

- Approximately 56% of high-cost claimants have a diagnosed mental health condition, compared with a rate of 37% among non-high-cost claimants. Depression is both the most common mental health condition present as well as one of the fastest growing conditions in terms of costs for high-cost claimants (both mental and physical).
- Furthermore, and importantly, about 13% of participants had diagnosed depression prior to their catastrophic event, with another 6% being diagnosed after their high-cost event.

The rise in mental health conditions, both the presence of these conditions and the coding frequency, increased significantly during the pandemic, and this trend is expected to continue for the foreseeable future. Given the noted correlations and potential impacts on physical outcomes, treating mental health should be considered a part of the full scope of care in managing high-cost participants. Plan sponsors need to consider effective treatment strategies for mental health conditions, including how best to assess quality, ensure access and determine what role telebehavioral health ought to play.

What Can Plan Sponsors Do to Manage High-Cost Claims?

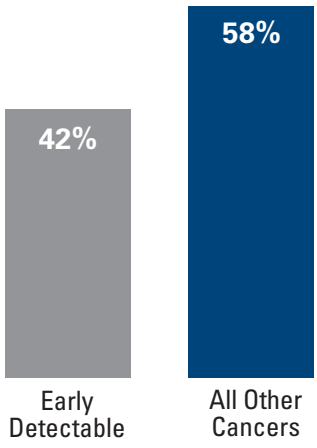
High-cost claims have inherent differences across populations, industries and geographic regions, so the first step should be to understand who the most likely high-cost claimants are within a given population and the prevalence of the risk factors previously discussed. Once a plan sponsor has a better understanding of who its high-cost claimants are, it's time to consider viable prevention and wellness strategies. Once that is understood, plan sponsors should consider the following initiatives.

Develop a Data-Driven Strategy

One cannot manage what cannot be measured. Consequently, having a data-driven strategy is important since it provides answers to key questions and gives plan sponsors the information needed to focus their cost-management

FIGURE 5

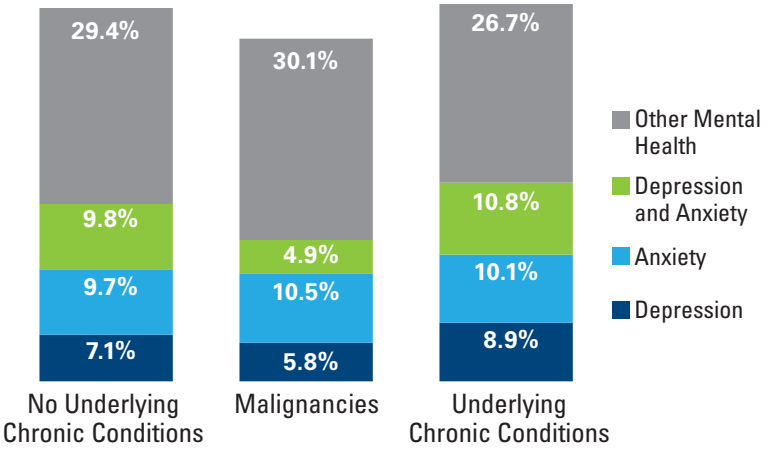
High-Cost Claimants With Cancer



Source: Segal's SHAPE data warehouse.

FIGURE 6

High-Cost Claimants and Mental Health



Source: Segal's SHAPE data warehouse.

strategies and evaluate the success of the initiatives they implement. Consolidated data from all carriers at a patient level (i.e., medical claims, prescription drug claims and other population health management programs, such as biometric screenings, on-site clinics and digital health) has been proven to be invaluable information when building best-practice cost-management programs.

The most effective way to manage costs is by proactively managing health risks. It's a good idea to have a dashboard of both current high-cost claimants and risk characteristics likely to progress to high-cost status and monitor it monthly. The dashboard should include not only the primary diagnosis or highest cost claim for the claimant but also the full scope of demographic info and underlying physical and mental health information.

Focus on Preventing and Managing Chronic Diseases

Most high-cost claimants have one or more major chronic conditions (i.e., diabetes, hypertension, COPD, CAD, CHF). Many programs now exist that give participants the tools they need to manage their condition(s), often through a smartphone app and tracking technology. Choosing the right program will be dependent on the specific population and participants' acceptance of such programs. When contemplating addition of a chronic condition management program, it is important to consider the following.

- Which participants could benefit most from intervention
- The most effective communication method(s) for engaging participants in the population (e.g., email, direct mailing, text messaging, etc.)
- Performance goals and methods for evaluating the program
- The amount of fees at risk for not meeting performance goals
- To what extent mental health professionals are integrated into the program

Aside from programs to manage chronic conditions, plan sponsors can double down on efforts to promote nutritional and heart-healthy lifestyles, improve medication adherence and raise awareness on the benefits of getting recommended cancer screenings. In addition, hearing testimonials from co-workers can help reduce stigma and raise awareness on effective methods for managing these conditions.

Whenever population health management strategies are implemented, it is important for plan sponsors to take a long-term view. Programs often raise costs in the near term as members become more engaged in their health and more adherent to medications. Further, plan sponsors will not necessarily be aware when a high-cost event has been avoided. Patient plan sponsors should be rewarded with stable or improving population health and may also benefit from increased worker productivity as a result.

Implement Intensive Medical/Case Management

Overall, the goal of medical/case management is to coordinate care for the most complex patients, often those who are facing multiple chronic conditions. From the initial identification of patients in need to coordination of care and communication across settings and providers, as well as evaluation of patient outcomes, care management provides whole-person and patient-oriented care to help high-need patients and their families and caregivers effectively manage their conditions.

As the health care system shifts from a fee-for-service structure to value-based payment programs,[3] appropriate provision of services across the care-management continuum can increase value and improve outcomes for patients while effectively reducing unnecessary care and acute-care episodes that require high-cost interventions.

Successful care management should produce the following benefits.

- Reduce the likelihood of a patient receiving duplicative or low-value services in low-quality settings
- Ensure that the support structure is in place to help the patient seek care
- Provide an opportunity to negotiate costs for services, such as outpatient rehab and home health care
- Offer convenient, high-quality care options to participants, such as centers of excellence (COEs), for their particular condition or conditions
- Make available expert medical opinions to ensure the right care at the right time and in the right setting for both the physical and mental conditions present

Establish COEs and Bundled Payment Programs

COEs provide high-value health care, often at lower prices than other medical centers. The COE provider identifies top-quartile hospitals and surgical centers—by practice, procedure and specific physician group—and negotiates with these high-performing surgical teams for episode-of-care case rates, bundling the various charges for each surgery into a single price at a significantly lower cost and avoiding the uncertainty experienced through typical fee-for-service arrangements.

Using COEs for certain elective procedures (e.g., joint replacements), care for other complex conditions (e.g., cancer or cardiac issues) or diagnostics typically results in immediate savings. Spinal disorders, in particular, are one of the leading causes of elective surgeries and high-cost claims, representing approximately 5% of all high-cost claims. The cost of spinal surgeries can vary significantly, especially when complications are introduced. Having a bundled payment arrangement in place can ensure that plans are not subject to the financial uncertainty around these procedures. *Bundled payments* are lump-sum payments made for an episode of care. With bundled payments, the total allowable expenditures (target price) for an episode of care are predetermined. Participant providers share in any losses or savings that result from the difference between this target price and actual costs. One COE vendor recently announced that its contracts cut employer spending for covered services by about half by reducing the cost of surgeries, reducing hospital readmissions and avoiding some procedures entirely. That figure may be an outlier that's partially the result of clever framing, but sizeable savings often exist for most plan sponsors when they are aligned with the right partner.

In addition to elective procedures, oncology care is emerging to be one of the areas where COEs excel. The more familiar the facility/oncology team is with treating certain complex types of cancers, the better they get at providing more efficient care. The new, cutting-edge cancer care infusion treatments are very expensive; thus, precision matters. Having experienced oncology teams will eliminate trial and error and ensure that the right care is delivered the first time. After spinal disorders and septicemia, certain types of cancer—particularly breast and colorectal cancer—are consistently a top-ten cause of a high-cost event. Using value-based COEs for cancer treatment is one of the best tools available to mitigate the financial uncertainty around cancer treatment while improving outcomes for plan participants.

Manage Prescription Drug Utilization

According to data in Segal's SHAPE data warehouse, specialty drugs accounted for less than 2% of prescriptions but 45% of total drug spend in 2021, up from 41% in 2018. Inflammatory conditions, diabetes, oncology, HIV and multiple sclerosis are the top five primary drivers of specialty prescription drug spending.

In general, an emphasis on preventive care and a strong approach to chronic disease management can go a long way in reducing health care spending, including prescription drug spending. Following are some additional strategies for prescription drug cost management.

- Having tighter prescription management and formulary controls in place
- Using programs like prior authorization, split fill, step therapy or drug tiering
- Buying better network provider deals—aggressively pursuing best pricing for a specialty drug PBM contract (trade exclusivity for deeper discounts)
- Deciding which channel (medical plan or PBM) is most cost-effective for delivering specific medications

Consider a Stop-Loss Policy

Plan sponsors may also want to also do a deeper dive into their high-cost claims expenses and consider appropriate stop-loss coverage. Depending on population size and reserve levels, stop-loss coverage may not be appropriate for all plans, but for smaller groups and/or groups with inadequate reserve levels, stop-loss coverage can provide a viable solution for transferring high-cost claims risk to an outside vendor or at least ensuring the plan stays within its desired risk tolerance.

Evolving treatments, such as the glucagon-like peptide-1 (GLP1) receptor agonist drugs for diabetes and obesity as well as gene therapies that can cost more than $1 million, are becoming more and more common. Many more are in the pipeline, as noted in Table II. As of September 2022, three

new gene therapies were approved in the U.S.: Kymriah®, Luxturna® and Yescarta®.

The gene therapies currently on the market cover very rare conditions and should not affect most populations. However, with 50–100 additional gene therapies in the pipeline that are anticipated to receive Food and Drug Administration (FDA) approval by 2025, plan sponsors should brace for the impact and develop strategies accordingly.

Oncology is the most active therapeutic area being studied, with 20 gene therapies currently in development. Gene therapies being developed for other conditions, such as hemophilia, will have a much larger pool of potential candidates than the therapies that are currently on the market. When making decisions around coverage of these treatment options, it is important for plans to look at the cost of not only these therapies but also other treatment options on the market that participants will pursue if gene therapies are not attainable.

The marketplace for stop-loss coverage is also evolving to provide specific treatment-related insurance safety nets. If plans have data analytic capabilities available, they can proactively identify how many plan participants may be eligible for emerging gene therapies and/or other expensive treatments and help structure the appropriate stop-loss policy to have in place.

Stop-loss coverage should be implemented in combination with a robust clinical services program—from simple reporting to comprehensive clinical review and engagement—to address the rising number of high-cost claimants while maintaining competitive stop-loss premiums.

In addition, plan sponsors should investigate the origin of claims to make sure the plan is not paying for other insurer/third-party liabilities (i.e., subrogation). For instance, plan sponsors should make sure they are not paying high amounts for claims that should be covered by auto insurers if the claims result from accidents.

TABLE II

Gene Therapies Approved for Use in the United States

Brand	Generic	Year Approved	Disease	Company
Carvykti™	ciltacabdagene autoleucel	2022	R/R multiple myeloma	Janssen Biotech
Zynteglo®	betibeglogene autotemcel	2022	beta thalassemia	bluebird bio
Skysona®	livaldogene autotemcel	2022	cerebral adreno-leukodystrophy	bluebird bio
Zolgensma®	onasemnogene abeparvovec	2019	spinal muscular atrophy	Novartis
Tecartus™	brexucabtagene autoleucel	2020	mantle cell lymphoma	Pharma (Gilead) Kit
Breyanzi®	lisocabtagene maraleucel	2021	DLBCL	Juno (Bristol Myers Squibb)
Abecma®	idecabtagene vicleucel	2021	multiple myeloma	bluebird bio

Source: U.S. Food and Drug Administration, Approved Cellular and Gene Therapy Products, www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/approved-cellular-and-gene-therapy-products.

Conclusion

Health care in the U.S. is constantly evolving. New treatments and technologies are being developed, and there are changes in the way care is delivered and compensated. Market demand for services shifts. Those are just a few factors contributing to the evolution of health care.

Likewise, the characteristics of high-cost care are a moving target that is highly variable from plan sponsor to plan sponsor. Fortunately, plan sponsors can develop strategies to reduce or mitigate the effects of high-cost care.

It is critical for these activities to be guided by relevant and up-to-date

plan data as well as relevant and current clinical knowledge and market expertise. Just as there are innovations in treatment and care delivery, there are innovations in improving quality and efficiency.

It is also important for plan sponsors to take a long-term view of their high-cost participants and take action to improve participant health—including addressing lifestyle factors, engagement with the health care system and treatment adherence—as early as possible to reduce the risk of progression to more severe comorbidities. BQ

Endnotes

1. A. Rodriguez (August 5, 2020). "Healthcare costs increased twice as fast as worker wages over last decade." *American Journal of Managed Care.* Retrieved October 4, 2022 from www.ajmc.com/view/healthcare-costs-increased-twice-as-fast--over-last-decade.
2. Segal's SHAPE data warehouse is a database of over 2.4 million lives spanning the corporate, public and multiemployer markets. Only participants not enrolled in Medicare were included in this article.
3. *Value-based payment programs* are alternate forms of reimbursement that tie some portion of provider payments to outcomes or performance on select quality measures with the goal of improving both effectiveness and efficiency of care.

AUTHORS

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My QDIA Is Better Than Your QDIA

by **Jack M. Towarnicky, CEBS** | *Of Counsel, Koehler Fitzgerald, LLC*

"Better" Is in the Eye of the Beholder

In early 2005, almost 18 years ago, long before the Pension Protection Act of 2006 (PPA 2006)[1] became law and long before associated qualified default investment alternative (QDIA) regulations were adopted,[2] members of my 401(k) plan's investment fiduciary committee were comparing default investment alternatives. We needed a default for the increasing number of "one-offs" where we lacked participant (survivor, beneficiary) investment direction. We also wanted to have a default in place as soon as practical because our plan's settlor committee was expected to amend our plan to add aggressive, perennially applied, innovative, automatic features. To minimize complexity and confusion, we wanted our investment structure (the core investments and QDIA) to be in place long before implementing automatic features in April 2007.

Our 401(k) plan was unique. Nearly 20% of participants who owned 30% of all plan assets were term-vested workers, retired workers, or surviving spouses and beneficiaries who had left some, most or all of their assets in the plan.[3] So our participants were very diverse, ranging in age from 18 to 95-plus. We had participants who just made their initial contribution versus those with seven-digit account balances. We had recent hires versus some who had participated for almost 40 years (today approaching 55 years) and some who were receiving annual installments to comply with the required minimum distribution (RMD) rules.

Before PPA 2006 and QDIA regulations, we considered several alternatives, including the defaults that others used. We added a money market investment option in 1993 to meet the requirements of Section 404(c) of the Employee Retirement Income Security Act (ERISA) but decided that it was inappropriate as a retirement savings default. We considered using our guaranteed investment contract (GIC) that was added in May 1980. In the fourth quarter of 2005, the GIC's guaranteed yield was about 6%. However, we rejected the GIC because it included provisions that could inhibit a participant's ability to transfer.

Next, we considered adding a series of three lifestyle funds, where the conservative version would be the default—even though we still offered a defined benefit pension plan (neither frozen nor closed to new entrants). We also looked

AT A GLANCE

- Unlike target-date funds (TDFs), target-date models (TDMs) show transparency by confirming asset allocations to participants at least five times each year.
- TDMs can be personalized to accommodate even the most diverse participant populations.
- The combination of transparency, personalization and quarterly and biannual investment reviews of the core investments may minimize the fiduciary risk exposure from selecting a qualified default investment alternative (QDIA).

at the balanced fund we added in 1996. However, we had no basis for selecting either as the QDIA. We never considered managed accounts. Obviously, we needed a default for those who failed to provide investment direction.

Finally, we considered adding ten to 12 target-date funds (TDFs). Initially, it seemed like a TDF series was the best choice—something that at least offered some personalization (by year of birth in five-year cohorts). But adding another 12 investment choices would take us in the wrong direction. Increasing the number of choices from 47 to almost 60 would have added to already-evident participant choice blindness while introducing mixed-use issues[4]—inconsistent with the already-underway discussions to reduce investments to a number that would be more manageable, less cumbersome, less confusing and easier to understand.

Our service provider identified a different solution—target-date models (TDMs). *TDMs* are a series of no-fee, fully transparent, electronic instructions that allocate assets across some of the core investment options in a manner designed to mimic TDF glide paths and landing points. We coupled adoption of those models with a decision to reduce the number of core investment options from 47 to 15 while also adding a directed brokerage feature to finesse the reduction in core investments.[5]

Superior/Defensible Outcomes, Exceptional Results

Most importantly, because models are 100% transparent, participants can pull information from the plan's website to confirm their asset allocation on any business day. Further, the plan will push to each participant a quarterly statement that highlights both percentage and dollars-and-cents allocations of assets across the core investment choices. The disclosures minimize confusion.

TDMs offer many advantages over TDFs, including but not limited to the following.

- The plan investment fiduciary decides the glide path, landing point and rebalancing frequency and updates these features biannually as necessary.
- Each core investment is evaluated against an appropriate benchmark each quarter.
- Performance and fees are explicitly disclosed to participants via quarterly statements.
- Quarterly statements can include measurements of TDM performance and fees against a custom, weighted benchmark.
- The models embrace the "open architecture" of the core investments. They are not limited to the TDF's proprietary "fund-of-funds" managers. So, underperformance by any one manager isn't hidden by reports of aggregate performance.
- Because core investments are "white labeled" collective investment trusts (CITs), there is no resistance or inertia, nor any blackout period, where the underperforming investment manager of a core fund is replaced—allowing for fast action while avoiding participant disruption. Changes in core investment managers concurrently apply to the TDMs.
- Limiting core investments (or the TDMs) to passive, index investments, coupled with directed brokerage, may also reduce fiduciary risk.[6]
- Each reallocation along the glide path is disclosed to participants in detail, with a notice in advance of the reallocation of assets and a notice after the reallocation across the core investments.
- Tactical allocations are not permitted.
- Asset allocation is confirmed five times annually and may ensure that participants have "actual knowledge."[7]
- Participants can confirm the allocation of their account assets online, any time, any day.
- Participants are specifically informed about the glide path's operation and process, including rebalance frequency, landing point, etc. The *target date* is clearly defined as the payout commencement date. The *landing point* is clearly defined as the date at which equity allocations are minimized while incorporating information regarding sequence of returns risk.
- TDM allocations apply to all assets. Those who wish to overweight or underweight an asset class or use via directed brokerage must make an affirmative investment election—so there is no mixed-use investing.
- Model glide paths need not be limited to years ending in 5 or 0—avoiding "0 bias."[8] They can vary by year of birth and/or based on sex and/or marital status (acknowledging mortality differences). Other variables

can be incorporated into a hyperpersonalized TDM—but only with participant guidance.[9]

- Concentrating assets in five, ten or 15 core investments may achieve economies of scale—increasing bargaining power over asset management and other fees.[10]
- TDMs may avoid numerosity, complexity and choice blindness.
- The models are a great match for the typical plan participant using the QDIA who may be financially illiterate and/or innumerate.[11]
- When coupled with directed brokerage, and perhaps deemed individual retirement accounts (IRAs), participants can select any TDF they prefer and allocate their money to an investment that provides guaranteed income—without adding to investment fiduciary risk.[12]
- Participants always retain 100% control over the allocation, glide path, landing point, etc., because the glide path, the landing point (percentage of assets, date) and the frequency of rebalancing can be personalized. Participants can construct their own model.
- Most recordkeepers already have functionality in place to support TDM processing.

Plan investment fiduciaries may know very little about each participant's financial circumstance. However, even if the only known variables are birth year, sex and marital status, using TDMs that vary allocations based on those criteria as the QDIA offers many more opportunities to customize/personalize asset allocations when compared with both standard and customized TDFs.[13]

As a QDIA, a TDM may be better at achieving an outcome consistent with both the rule and the spirit of the applicable statute [14] and regulations.[15]

This description is mostly focused on a structure first adopted more than 15 years ago. In the future, TDM processes could perennially prompt participants to hypercustomize/personalize their allocations through annual outreach, perhaps starting upon attainment of age 50. Any decision to adjust the asset allocation based upon the participant's provision of specific data and information would require the participant to confirm the change as a participant-directed, affirmative investment election (no longer a QDIA). Hypercustomization/personalization would not be limited to active participants, nor would it exclude participants in a payout status. BQ

My comments are my own based on my past experiences in plan sponsor and consulting roles and do not necessarily reflect those of any employer or association I have been employed by or affiliated with, past, present, or future. Information was provided by individuals with knowledge and experience in the industry and not as legal or tax advice. The issues presented here may have legal implications, and you should discuss this matter with legal counsel prior to choosing a course of action. This article is intended to be informational only. It is not (and you/others should not use it as) a substitute for legal, accounting, actuarial or other professional advice. Any advice contained in this article was not intended or written to be used and cannot be used by anyone for the purpose of avoiding any Internal Revenue Code penalties that may be imposed on such person [or to promote, market or recommend any transaction or subject addressed herein]. You (others) should seek advice based on your (their) particular circumstances from an independent tax advisor.

Endnotes

1. Pension Protection Act of 2006, Pub. L. 109-280. Accessed 2/2/23 at www.govinfo.gov/content/pkg/PLAW-109publ280/pdf/PLAW-109publ280.pdf.

2. 29 CFR § 2550.404c-5 Fiduciary relief for investments in qualified default investment alternatives. Accessed 2/2/23 at www.ecfr.gov/current/title-29/subtitle-B/chapter-XXV/subchapter-F/part-2550/section-2550.404c-5.

3. That is much more commonplace today. According to 5500 filings, the percentage of plan participants in single employer defined contribution plans who are not active participants (term vested, retired, surviving spouse, beneficiary) has increased nearly tenfold, from 2.6% in 1975 to 22.7% in 2020. Accessed 2/3/23 at www.dol.gov/sites/dolgov/files/ebsa/researchers/statistics/retirement-bulletins/private-pension-plan-bulletin-historical-tables-and-graphs.pdf.

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5. J. Towarnicky, 8/28/21 written statement to the Employee Retirement Income Security Act (ERISA) Advisory Committee. "The investment fiduciaries . . . added directed brokerage effective March 15, 2006. It was part of a full restructuring of plan investments. The goals included (1) simplifying the core investment lineup—ensure clear distinctions among the available choices, (2) improving fiduciary oversight of core fund investment managers and implementing structural change that would allow the plan investment fiduciaries to change investment fund managers without disrupting participant saving and investment decision making, (3) lowering asset management fees which were all paid by participants, (4) adding target-date models (TDMs) as the qualified default investment alternative (QDIA) and (5) adding a self-directed brokerage account option to facilitate the transition to a much smaller and significantly different set of core investment options. The changes followed an extensive review by the plan's investment fiduciary—with significant input from third party investment professionals."

6. J. Towarnicky, "Tripping Over Our Own Fee(t)s: Can Plan Sponsors Avoid a Myopic Focus on Fees?" *Benefits Quarterly,* Third Quarter, 2022.

7. *Intel Corp. Investment Policy Committee v. Sulyma,* 589 U.S. ___ (2020) "The Employee Retirement Income Security Act of 1974 (ERISA) requires plaintiffs with 'actual knowledge' of an alleged fiduciary breach to file suit within three years of gaining that knowledge, 29 USC §1113(2), rather than within the 6-year period that would otherwise apply. . . . *Held:* A

plaintiff does not necessarily have 'actual knowledge' under §1113(2) of the information contained in disclosures that he receives but does not read or cannot recall reading. To meet §1113(2)'s actual knowledge requirement, the plaintiff must in fact have become aware of that information. Pp. 5–12." Accessed 2/2/23 at supreme.justia.com/cases/federal/us/589/18-1116. See also *Sulyma v. Intel, Corp.*, 9th Cir., No. 17-15864, 11/28/18. "The key is that . . . the limitations period begins to run once the plaintiff has sufficient knowledge to be alerted to the claim. . . . we emphasize that . . . the plaintiff must have *actual* knowledge, rather than constructive knowledge. . . . . [t]he statutory phrase 'actual knowledge' means what it says: knowledge that is actual, not merely a possible inference from ambiguous circumstances." Section 1113 uses this statutory phrase, and Congress removed the constructive knowledge provision from the statute in 1987. To prevail on a statute of limitations defense on a section 1104 claim, as here, therefore, the defendant must show that there is no dispute of material fact that the plaintiff was actually aware that the defendant acted imprudently. Accessed 2/2/23 at cdn.ca9.uscourts.gov/datastore/opinions/2018/11/28/17-15864.pdf.

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9. For example, a plan can have a specific asset allocation, glide path and landing point for an unmarried man born in 1958 that varies from the asset allocation, glide path and landing point for a married woman born in 1962 (where, otherwise, both were likely to be invested in a 2025 TDF with the same asset allocation). Models are not limited to traditional "to" or "through" glide paths but can include a "U shape" for equity allocations in anticipation of asset retention, account consolidation, asset aggregation and income payout—and as a means to moderate the impact of sequence of returns risk. Further, a participant can hyperpersonalize their target-date model by supplying additional information (salary, other benefits, specific target date, rebalance frequency, etc. to create their own model).

10. M. Massa, R. Moussawi, A. Simonov, *The Unintended Consequences of Investing for the Long Run: Evidence from Target Date Funds,* 11/1/20. "Our evidence suggests that asset managers exploit reduced investor attention to deliver lower performance. This results in a hypothetical cumulative return loss of 21% for the average investor holding the fund for 50 years. We find that this underperformance is driven by fund families using TDFs to smooth the flow shocks by overweighting affiliated open-end funds in the TDF portfolio. It also results from the higher fees arising from investing in the affiliated expensive share classes." Accessed 2/2/23 at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3729750. See also: O. Mitchell, S. Utkus, *Target Date Funds and Portfolio Choice in 401(k) Plans,* May 2021. "The adoption of low-cost target date funds may enhance retirement wealth by as much as 50 percent over a 30-year horizon." Accessed 2/2/23 at www.econstor.eu/bitstream/10419/246874/1/177803134X.pdf.

11. O. Mitchell, A. Lusardi, *Financial Literacy and Planning: Implications for Retirement Wellbeing,* May 2011. "We show that financial illiteracy is widespread among older Americans . . . our special financial literacy and planning module included three questions on financial literacy, as follows: (1) Suppose you had $100 in a savings account and the interest rate was 2% per year. After 5 years, how much do you think you would have in the account if you left the money to grow: more than $102, exactly $102, less than $102? (2) Imagine that the interest rate on your savings account was 1% per year and inflation was 2% per year. After 1 year, would you be able to buy more than, exactly the same as, or less than today with the money in this account? (3) Do you think that the following statement is true or false? 'Buying a single company stock usually provides a safer return than a stock mutual fund. . . . disturbing is the fact that only one-third (34 percent) of respondents can correctly answer all three questions.'" Accessed 2/2/23 at www.nber.org/system/files/working_papers/w17078/w17078.pdf. See also M. Harvey, C. Urban, "Does financial education in high school affect retirement savings in adulthood?" February 2022. "Our results show no definitive increases in account ownership, non-retirement investment accounts, or homeownership." Accessed 2/2/23 at www.tiaa.org/content/dam/tiaa/institute/pdf/research-report/2022-01/tiaa-institute-does-financial-education-in-high-school-rd-185-harvey-urban-february-2022.pdf.

12. N. Zuss, "Annuities Gain Steam as Part of Target-Date Funds," 10/20/22. Accessed 2/2/23 at www.plansponsor.com/annuities-gain-steam-part-target-date-funds. Author's note: These and other TDFs, as well as other mutual funds, can be made available via a directed brokerage account. Consider the related 2021 ERISA Advisory Council report *Understanding Brokerage Windows in Self-Directed Retirement Plans,* December 2021. "In 2010, the Department issued participant disclosure regulations pursuant to ERISA Section 404(a). These regulations define a designated investment alternative, and then in turn define a brokerage window by excluding it from the definition of a designated investment alternative and stating that a brokerage window 'enables participants and beneficiaries to select investments beyond those designated by the plan.' . . . In footnote 27 of the preamble to the regulations issued under ERISA Section 404(c) in 1992, the Department points out that 'the act of limiting or designating investment options which are intended to constitute all or part of the investment universe of an ERISA 404(c) plan is a fiduciary function.' By negative implication, some interpret this footnote to mean that if there is no 'act of limiting or designating investment options'—such as by allowing investments through an unrestricted brokerage window—the fiduciary can receive ERISA Section 404(c) relief.

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Further, the amendments to these regulations in 2010 state that ERISA Section 404(c) relief 'does not serve to relieve a fiduciary from its duty to prudently select and monitor any . . . designated investment alternative offered under the plan.' By indicating that there is a fiduciary duty to prudently select and monitor designative investment alternatives, the regulation suggests that no such obligation applies if investments are unrestricted." Accessed 2/2/23 at www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/about-us/erisa-advisory-council/2021-understanding-brokerage-windows-in-self-directed-retirement-plans.pdf.

13. U.S. Department of Labor, Employee Benefits Security Administration, *Target Date Retirement Funds—Tips for ERISA Plan Fiduciaries,* February 2013. "Inquire about whether a custom or non-proprietary target date fund would be a better fit for your plan. Some TDF vendors may offer a pre-packaged product which uses only the vendor's proprietary funds as the TDF component investments. Alternatively, a 'custom' TDF may offer advantages to your plan participants by giving you the ability to incorporate the plan's existing core funds in the TDF. Nonproprietary TDFs could also offer advantages by including component funds that are managed by fund managers other than the TDF provider itself, thus diversifying participants' exposure to one investment provider. There are some costs and administrative tasks involved in creating a custom or nonproprietary TDF, and they may not be right for every plan, but you should ask your investment provider whether it offers them." Accessed 2/2/23 at www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/target-date-retirement-funds.pdf. See also: K. Knowles, *Eight Observations on Custom Target Date Funds,* Revised July 2019. "1. Evaluating participant demographics . . . leads to interesting findings for heterogeneous populations, 2. . . . a DB plan can be accounted for . . . 3. . . . benefits to customizing . . . beyond the . . . glide path, 4. . . . thoughtful mix of active and passive management, 5. Many . . . select multi-manager structures to manage the sleeves and core line-ups, 6. . . . benefits to being dynamic in both the short term and the long term, 7. . . . selected glide path manager will also be an operational partner . . . 8. Performance evaluation is important and should be based on clearly stated (documented) objectives. . . . a target date fund series is built around one 'typical participant' who is deemed to be representative of an entire population. Off-the-shelf target date funds model that participant based on average characteristics of the general population. Custom target date funds can be modified to take into account specific characteristics unique to the participant base." Author's note: Custom TDFs may be unique to the participant base; however, TDMs (varied by year of birth, sex and marital status) are unique to each individual participant. Accessed 2/2/23 at https://russellinvestments.com/-/media/files/us/insights/institutions/defined-contribution/8-observations-on-custom-target-date-funds.pdf.

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15. 29 CFR §2550.404c-5 Fiduciary relief for investments in qualified default investment alternatives, Note 2 supra.

Using Lessons From COVID-19 Vaccine Hesitancy to Increase Retirement Plan Participation

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Vaccinations and employer-provided retirement plans are two examples of *merit goods*—goods that policy makers think people should consume. A major policy puzzle has been the refusal of many people in the United States to get vaccinated and boosted against COVID-19, even when the vaccines are free.

Similarly, many workers do not sign up for retirement plans offered by their employers despite matching contributions. It is important to understand and address why workers with access to retirement plans do not sign up for them. Retirement plans can be a significant source of retirement income. In 2021, 25% of private industry workers who had access to a retirement savings plan did not participate (BLS, 2021). Investigating approaches to encourage more of these workers to participate is the focus of this article.

During the COVID-19 pandemic, policy makers, medical personnel and public health specialists have been concerned about the large number of people resisting being vaccinated even though the vaccines are free, have been proven successful against a potentially fatal disease and have minimal side effects. Researchers have studied why some individuals decide not to be vaccinated as well as the demographic characteristics of these individuals. Based on their research, they have developed approaches to address the reasons for vaccine hesitancy and encourage people to get vaccinated.

This article looks into whether some approaches to addressing vaccine hesitancy might also be useful to policy makers and retirement plan providers concerned about workers not signing up for employer-provided plans or opting out. Hesitation to take COVID-19 vaccines and resistance to signing up for retirement plans might be motivated by similar factors, such as lack of information and lack of

AT A GLANCE

- Some of the approaches proven effective for dealing with COVID-19 vaccine hesitancy might be applicable for increasing retirement plan participation.
- Lack of trust and lack of knowledge contribute to plan participation hesitancy and can be addressed by educating employees about the plan provider and the features of the retirement plan.
- Messages to encourage retirement plan participation need to be tailored to the demographic and financial characteristics of the targeted groups of interest.

trust. If so, the approaches to dealing with vaccine hesitancy might be useful to those dealing with resistance to participating in retirement plans.

Overview of the Experience With Resistance to Retirement Plan Participation

Reasons for Participation Resistance

Surveys indicate that lack of trust is an important explanatory factor for resistance to participating in retirement plans (Bielawska, Shen and Turner, 2022; Bielawska and Turner, 2022). Only 30% of people in the U.S. trust their retirement plan provider, according to a National Association of Retirement Plan Participants trust and engagement survey (Malito, 2018). Participants said they didn't understand the fees they were paying for their retirement accounts and thought they weren't being told everything about those fees.

Tharp (2019) finds that people place more trust in financial professionals who have titles indicating that they are advisors than in those having titles indicating that they are focusing on sales, such as stockbrokers and insurance salespersons. In the United Kingdom, half (50%) of self-employed people surveyed say they do not trust pensions as a safe place to invest their money (compared with 42% of employees), and 12% of self-employed people say they do not know whether they trust pensions (Pension Policy Institute, 2020).

Agnew et al. (2012) find that workers with greater knowledge of retirement plan features and greater trust in financial institutions have greater participation. A 2018 Pew Charitable Trust survey finds that "workers who distrust financial institutions are less likely to participate in an employer-provided pension plan when one is offered" (Scott and Watson, 2018).

These surveys and studies suggest that trust in the retirement plan provider, along with an understanding of plan features, are important for increasing participation.

Characteristics of Those Who Are Resistant to Retirement Plan Participation

More than 70% of U.S. workers have access to employer-sponsored retirement plans, and 56% of these workers participate in these plans.[1] Employees with access to employer-provided retirement plans are more likely to work full-time, work in the public sector, belong to a union, earn higher wages and work for companies with 500 or more employees (CRS, 2021).

Workplace retirement plans account for the retirement savings that most U.S. workers have outside of Social Security. Yet many workers do not participate, even though they have access to employer-provided retirement plans. Reasons include not having enough money after taking care of immediate financial needs and having other savings goals, such as children's education or house down payments (Pew, 2017).

Workers with higher earnings are more likely to consider defined contribution (DC) retirement plans affordable. For example, 90% of those earning $100,000 or more participated, compared with 62% for those earning less than $25,000 (Pew, 2017). Education is an important factor in participation rates for DC plans. For example, 89% of those with a B.A. degree or more participate in DC plans, compared with 79% of those with some college education and 75% of those with a high school diploma or less. Those with more education are more likely to have higher earnings. More education is also associated with greater financial literacy, which means better understanding of the importance of saving for retirement (T. Rowe Price, 2022).

Race plays a role in retirement plan participation as well. Even with access to retirement plans, participation is likely to be lower for Black and Hispanic Americans than for whites. In 2021, plan participation for white wage or salary workers in the private sector was 57.7%, compared with 40.5% for Black workers and 31.9% for Hispanic workers (T. Rowe Price, 2022). Part of the explanation for the racial discrepancy in participation rates is that Black and Hispanic workers earn less than white workers on average. Black and Hispanic workers are also more likely to have all kinds of debt than white workers. Minority savers often have other financial priorities that make it difficult to save for retirement. Black and Hispanic Americans are more likely than white Americans to prioritize saving for their children's education, paying back their own student loans, paying down credit card or other types of debt, saving for emergencies and saving to buy a house (T. Rowe Price, 2022).

The discussion of participation in employer-provided retirement plans suggests that a number of factors might

affect whether a worker signs up for a retirement plan, including earnings level, education, other savings goals and the amount of debt owed. To be effective, outreach efforts will need to identify and address the specific reasons for retirement plan nonparticipation.

Overview of the COVID-19 Vaccine Experience

Reasons for COVID-19 Vaccine Hesitancy

Gallup surveys taken in 2021, the second year of the pandemic, show that 22-25% of people in the U.S. said they would refuse to get the COVID-19 vaccine (Jones, 2021). A survey in 2022 found that only 55% of people age 50 to 64 were willing to get a COVID booster shot (Rodriguez, 2022). According to these surveys, Americans resistant to vaccinations generally cite three main reasons. First, they want to wait to confirm the vaccine is safe or gets full Food and Drug Administration (FDA) approval (18%); second, they have already had COVID-19 and have antibodies (18%); or third, they don't trust vaccines in general (18%). Slightly fewer express concern about the time line for developing the vaccine as being too quick (14%), do not believe they would face serious health effects from the coronavirus (13%) or are concerned about an adverse allergic reaction (12%) (Jones, 2021).

In another poll taken in 2021, 37% of all registered voters who had not gotten vaccinated said that the reason was lack of trust in the vaccines. Related to lack of trust, 35% of registered voters said they were waiting to see the reactions to the vaccine from those who were getting vaccinated (Schulte, 2021).

The findings suggest that the provision of information about vaccines in general and the COVID-19 vaccine in particular (including its development, efficacy and possible reactions) might increase the take-up of the vaccine.

Characteristics of Those Who Are Vaccine Hesitant

Schulte (2021), the survey mentioned above, found that resistance due to lack of trust is higher among unvaccinated white, female, elderly, lower income and lower educated voters who live in rural and suburban areas. A study that analyzed vaccine hesitancy in the U.K. and Ireland found that those resistant to a COVID-19 vaccine were less likely to obtain information about the pandemic from traditional and authoritative sources and had greater levels of mistrust in these sources compared with vaccine-accepting respondents (Murphy et al., 2021).

The literature on vaccine hesitancy notes that the causes of vaccine hesitancy and, therefore, the approaches to addressing it vary across individuals and populations by factors including gender, race and level of education (Schmitzberger, 2021).

Drawing on the COVID-19 Vaccine Experience to Increase Retirement Plan Participation

COVID-19 Vaccine Strategies

Both government and private researchers have recommended strategies to address vaccine hesitancy (CDC, 2021; Schmitzberger, 2021). These strategies include messaging, financial incentives, and making vaccination easy and convenient. The studies mentioned above suggest that these strategies must be specific to the particular individuals and groups being targeted.

Examples of strategies to address vaccine hesitancy include the following.[2]

- Increase the awareness, knowledge and dissemination of vaccination information:
  - — Train trusted community, religious and political members as vaccine ambassadors who can talk knowledgeably about why people should get vaccinated. The vaccine ambassadors would address issues including mistrust and dis- and misinformation.
  - — Have doctors send reminders to their unvaccinated patients about the importance of getting vaccinated. These reminders could be conveyed by emails, phone calls, postcards or text messages. These reminders, in addition to educating the recipient about the vaccine, could also provide information on social norms, indicating, for example, that most people in their community are getting vaccinated.
  - — Have doctors engage in motivational interviewing and patient-centered conversations. designed to encourage patients to get vaccinated.

- Employ multiple vaccination strategies:
  - — Ensure convenient access to vaccination for all population groups
  - — Target population groups most likely to be unvaccinated or undervaccinated
  - — Use influential leaders to promote vaccinations
  - — Use a variety of media to get out the word about the importance of vaccinations.
- Tailor approach as much as possible to the targeted population group:
  - — Ensure that informational and educational material is culturally sensitive and available in various languages and literacy levels
  - — Personalize messages to appeal to emotions and interests of targeted groups
  - — Understand the reason(s) the person or community is vaccine-hesitant and address these issues
  - — Recognize that different populations may have different concerns about the COVID-19 vaccine in particular and vaccines in general.
- Consider financial incentives:
  - — Provide cash incentives to employees as many large private corporations did in 2021, including Amazon, Kroger, Petco, AutoZone, and Bolthouse Farms. These cash incentives ranged from $75 to $500 (CDC, 2021).
  - — Enroll people who get vaccinated in lotteries to win money or prizes (Hart, 2022). However, one study found that lotteries had limited effectiveness, perhaps because the probability of winning was so small.

Proposed Strategies for Increasing Retirement Plan Participation

Historically, the primary policy approach to increasing retirement plan participation was through tax incentives. More recently, that has been expanded for 401(k) plans to include employer matching contributions. Increasingly, employers and plan providers are using nudges, where employees are automatically enrolled in retirement plans but have the possibility to opt out. Financial education has also been used to reach out to employees about their plans. However, much workplace-based financial education involves seminars in which the information is not individualized and does not take into account demographic and economic differences across workers (Smith, 2016).

A review of strategies that address vaccine hesitancy suggests the following approaches might be useful for dealing with retirement plan participation resistance. These approaches differ from many of those currently used by employers and retirement plan providers in that they utilize multiple delivery channels for providing information and emphasize the importance of personalized messages.

- Increase awareness of retirement plans and the importance of retirement savings:
  - — Coordinate messages across the employer, benefits provider, plan sponsor, recordkeeper, advisor groups and other stakeholders.
  - — Use the following multiple channels to get out the information about retirement plans:
    - » Messages from leadership
    - » All-hands meetings
    - » Reminder postcards
    - » Webinars and virtual town halls
    - » Recordings that can be accessed outside of work
    - » YouTube/Facebook/Twitter.
- Solicit an employee doing a good job of saving to serve as an advocate
- Target different workers with different personalized messages and education:
  - — Adjust the message to the age of the worker
  - — Ensure that the informational and educational material is culturally sensitive and available in various languages and literacy levels (if relevant to the workforce)
  - — Personalize messages to appeal to the emotions and interests of the individual/group
  - — Recognize that different populations may have different priorities for saving (i.e., children's education, home down payment) and different levels of debt that need to be addressed.
- Employ multiple strategies and make goals actionable:

— Consider gamification to encourage people to learn and make the process fun; most information in finance is boring to the average worker
— Lower anxiety about complicated decisions
— Make signing up for a retirement plan easier and more convenient or establish autoenrollment.

Examples of These Approaches

- Increase awareness of the retirement plan and the importance of retirement savings:
  — Establish an annual drive during which the employer would encourage the participation of employees who have not signed up for retirement plans or opted out
  — Have supervisors reach out to their employees to learn about any concerns they might have about the plan for which they are eligible, let them know about the number of their co-workers who have signed up for the retirement plan and encourage them to consider participating.
- Target different workers with different personalized messages and education:
  — Send personalized emails to remind workers about their future older selves and their dependents as a way to think about signing up for the company retirement plan
  — Provide information that clearly shows the link between the worker's retirement savings contributions and the worker's retirement income. Research shows that such information has a greater effect on participation levels than the provision of general information about the plan (Goda et al., 2014).
- Employ multiple strategies, including nudges, nudges+, carrots, shoves and mandates (Stein and Turner 2022).
  — *Nudges* are any aspects of choice architecture that influence people's decisions without using mandates, significant economic incentives or overt persuasion (Thaler and Sunstein, 2009; Oliver, 2015). A common form of nudge is a default, where the worker is automatically enrolled in a retirement plan but can opt out.
  — *Nudges+* are nudge policies with overt persuasion, while *carrots* provide extra incentives for participation. One example is a retirement plan that enrolls participants in a lottery, which could be for money or prized goods, such as tickets to sporting events (Leonard, 1987; Mirrlees, 1997).
  — With *shoves,* the participant faces stiffer penalties. An example of a shove is the penalty tax generally levied in the U.S. on early retirement plan withdrawals.
  — With *contingent mandates,* the participant faces mandates if they make certain choices but can avoid the mandates by making other choices
  — Offer a small monetary incentive accompanied by peer influence to increase participation in retirement savings plans (Duflo and Saez 2003)
  — Provide brochures with specific information relating contributions to savings at retirement and annual income at retirement. Retirement planning software could be used to assist potential participants (Turner and Witte, 2009).

Discussion

Vaccines and employer-provided retirement plans are two examples of goods that policy makers think people should consume. Some of the approaches to deal with COVID-19 vaccine hesitancy might be applicable for increasing retirement plan participation, including influencing people who might opt out.

While the approaches that are suggested to address retirement plan participation resistance appear sensible, they have not been empirically tested for effectiveness. Future research should rigorously test the efficacy of the approaches identified here for increasing plan participation among those with access to employer-provided DC plans. BQ

Endnotes

1. In this article, we focus on those workers who have access to employer-provided retirement plans.
2. These suggested strategies are taken from CDC 2021 and Schmitzberger 2021.

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Democratizing Health Care: Providing Equal Access to Quality Care for All Covered Members

by **Dana Baker** | *Mayo Clinic Complex Care Program,* **Cheryl Nienhuis, CEBS** | *Mayo Clinic Complex Care Program* and **Brent Westra** | *Mayo Clinic Complex Care Program*

Accessing quality care for complex conditions can be challenging for all employees across an organization—from front-line workers to those in the corporate office. Concerns about out-of-pocket medical costs can lead to delayed diagnosis and treatment for health conditions that could have been more effectively managed (and less costly to treat) if they had been caught at an earlier stage.

But cost concerns aren't the only factors affecting complex care access. Other barriers—including social determinants of health, network limitations, proximity to referral centers and even lack of understanding about health plan offerings—can lead to higher rates of morbidity and mortality and higher risk for chronic illnesses.

Without equal access to quality care, employees may face poor health outcomes, and employers can be forced to deal with lost productivity and increased health care costs.

Benefit managers are in a unique position to have a positive impact on both employee access to complex care and their organization's financial picture. Robust benefit plan designs that are well-understood by members can reduce health disparities among employee populations and meet the financial needs of employers.

This article focuses on barriers to accessing complex care, the health and financial implications of getting it wrong and how benefit managers—in partnership with payers, providers and other vendors—can ensure equal access to quality care for all.

Understanding the Need for Improved Complex Care

U.S. health care spending reached $4.1 trillion in 2020.[1] And growing health care costs are only expected to climb. That's because much of today's health care spending is driven by care for medically complex and chronic conditions like heart disease, cancer and diabetes—the three leading causes of death and disability in the U.S.[2] It's estimated that the

AT A GLANCE

- Numerous barriers affect employees' ability to access quality care for complex conditions.
- Inaccessibility leads to poor health outcomes, lost productivity and increased health care costs.
- Benefit managers—in partnership with payers, providers and other vendors—can ensure equal access to quality care for all through an array of possible initiatives that create a positive patient experience, ensure better outcomes and save or control health care costs.

number of people with three or more chronic conditions will reach 83.4 million by the year 2030.[3]

But there's more to the complex care picture, including the following.

- Children with medically complex conditions (about 6% of the pediatric population) account for about 40% of pediatric health care spending.[4]
- Less than 10% of a plan's participant population spends 80% of plan dollars.[5]

Accounting for a large portion of these spending discrepancies are things like *diagnostic odysseys* (people wandering through the health care system looking for answers), overuse, misdiagnosis, inappropriate care and wrong treatment plans. For example:

- It's estimated that nearly one in five people told they have multiple sclerosis (MS) have been misdiagnosed. And many with an incorrect MS diagnosis begin and receive years of costly and unnecessary medications.[6]
- Nearly 10% of people with cancer receive no first-course treatment, which can lead to costlier care at later disease stages.[7]
- In 2020 alone, thousands of people who received spine surgery could have benefited from a more conservative treatment plan instead.[8]

The right access to the right treatment at the right time is key to improving health outcomes and reducing health care spending. It's also critical for employers' bottom lines. An analysis by the Integrated Benefits Institute found that poor employee health costs employers $575 billion annually. This is made up, in part, of 1.5 billion days of productivity loss from impaired performance, sick days, family medical leave, and short- and long-term disability usage.[9]

Barriers to—and Solutions for—Accessing Complex Care

Complex care is . . . complex. And accessing it can be even more complicated.

Health disparities, where a person lives, household finances and even limitations of a benefit plan can be significant barriers to receiving quality complex care. One study looking at outcomes for patients with a rare form of cancer found that proximity to and treatment at a referral center led to improved outcomes through better care and treatment plans.

Yet 46 million people—14% of the U.S. population—live in rural areas, often hours away from medical subspecialists and academic medical centers.[10] And those close to high-quality care aren't always able to access it. Other factors limiting a person's access to care include the following.

- Concerns about out-of-pocket costs and other financial barriers
- Insufficient insurance coverage
- Lack of knowledge about available benefit options
- Lack of understanding about their condition
- Transportation

Benefit plans incorporating defined complex care programs may be the solution for improving care, removing barriers and offering employees a valued benefit—the peace of mind of knowing that if they have a serious or complex medical need, their employer has ensured they will be able to get the care they need.

Complex care programs offer employers and payers a new kind of partnership that can take some of the stress and burden out of care coordination, giving employees access to the best care and saving employers money in the long term.

The figure on page 37 displays a sample patient journey in one provider's complex care program.

Preparing to Partner for Complex Care

Identifying partners to support employees with complex health care needs is one great step toward ensuring health equity across an organization. Employers considering adding a complex care program to their benefits plan should make sure to do the following.

Understand Areas of High Spend and Trend

Is the organization spending more on cancer care? Is there a large population seeking spine surgery? Understanding areas of high spend and trend can help during the search for complex care partners. A benefits broker or consultant may be able to suggest areas where the organization should focus and provide a list of solutions or opportunities to better address these complex care needs.

Don't Overlook Prescription Drug Costs

Employers should look at their prescription drug costs and consider what they're spending on high-cost medications for conditions with a high misdiagnosis rate, like MS. Are these members correctly diagnosed? Are they getting better? Are they getting the best possible care?

Reconsider Flagging Thresholds

Self-funded plans in particular should consider flagging spending on a claim long before it reaches the $100,000 or $200,000 mark. They can identify and support potential high-cost claimants earlier in the journey by flagging lower spend amounts associated with high frequency of care, multiple specialist or emergency visits, and/or specific diagnoses or medications.

Identify and Remove Barriers

Employers should look for solutions that reduce out-of-pocket costs and the mental barriers or burden of coordinating travel, lodging and care.

Employers don't have to solve for all their complex care needs at once. Those looking for a complex care partner can consider starting with one or two areas of need. There are vendor program solutions available that can make a big impact no matter the size of the organization.

Other Ways Benefit Managers Can Build Plans That Ensure Health Equity

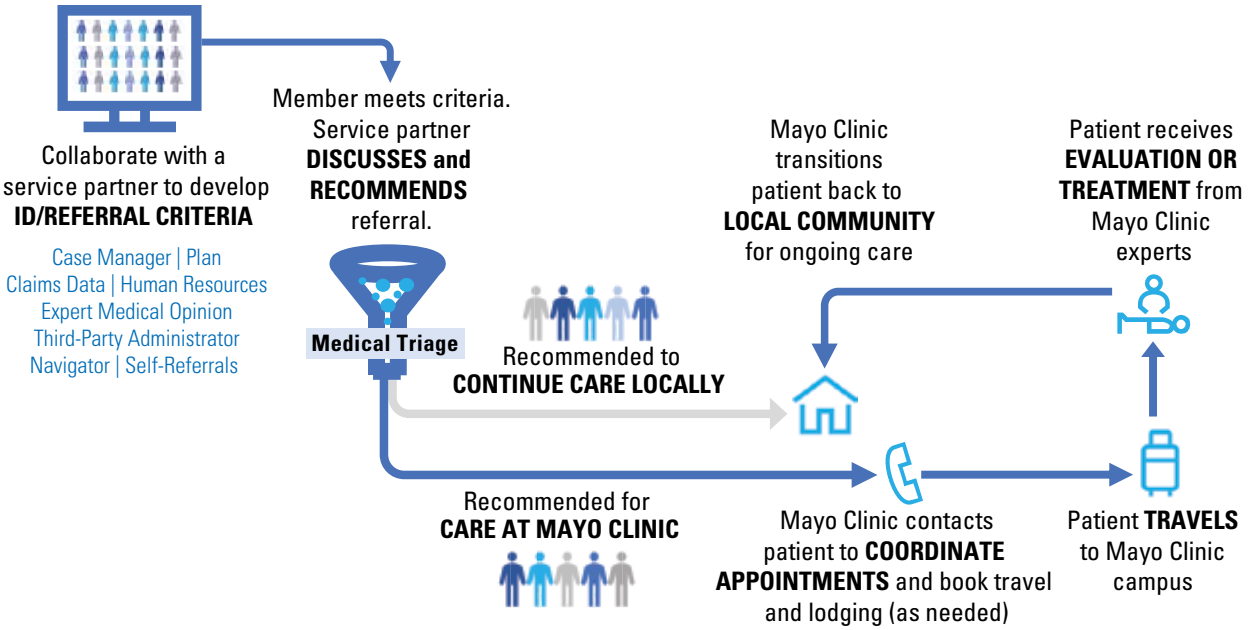
Benefit managers can do many things beyond implementing complex care programs to support the health of their employee population.

Take a Broader Approach to Preventive Care

The U.S. Preventive Services Task Force recommendations are a great place to start when it comes to outlining coverage for preventive care and screenings. But even these national guidelines can be limiting for certain populations at higher risk for developing conditions like diabetes, chronic kidney disease and cancer. A June 2022 study, for example, recommended lower body mass index (BMI)

FIGURE

Mayo Clinic Complex Care Program: Patient Identification and Journey



and age thresholds for diabetes screening among Asian, Black and Hispanic Americans.[11]

Benefit managers should review updated research to see where it contradicts current screening recommendations and then work with brokers or consultants to identify vendor partners and plans that will cover screenings across their entire employee population using updated criteria.

Embrace Technology and Virtual Care, But Understand Its Limitations

Technology is critical for the democratization of health care. Predictive modeling and data mining are great tools for understanding member populations and getting them access to the right care. Search optimization can support a better experience across benefits platforms. And virtual care delivery may work well for primary and mental health care needs, but virtual visits have their limitations when it comes to complex care

When a person's primary care needs turn into specialty care needs, for example, virtual visits could delay necessary in-person care. For some, virtual specialty care may not even be an option since these visits aren't always available across state lines. It's important to understand the limits of virtual care technologies and have a streamlined process in place to ensure that access to complex care isn't compromised or made more challenging.

Find Better Ways to Communicate Plan Offerings

A survey by the International Foundation of Employee Benefit Plans found that, despite many organizations putting effort toward benefit communications, only about a third felt their plan participants had a high level of understanding about their health or retirement benefits.[12]

Benefit managers should make sure that life event topics are easy to access on benefits or communication platforms. They can create categories where employees can go to access all the information they need on specific topics, with details about what benefits support is available.

They can also make benefits part of their broader internal communication strategy. For example, they can show or tell employees how their benefits can support them or a loved one and include additional available resources.

In one example of an innovative communications technique, a large trucking employer challenged by a mobile and widespread workforce created audio communications to play on rotation in truck cabs. These frequent reminders offered details on important benefit programs.

Figure Out How to Meet the Needs of a Hybrid Workforce

The COVID-19 pandemic changed the way we work. With so many employees coming to the office less fre-

Better Outcomes and Cost Savings

Several organizations work with employers to provide access to high-quality care. In addition to complex care programs, some providers offer access to center of excellence (COE) networks, which are teams or facility groups that take an interdisciplinary approach to meet the needs of people with complex and multiple chronic conditions.

These programs can save money and provide higher quality care through accurate diagnosis and proper treatment as well as by removing barriers to care.

For example, the Mayo Clinic Complex Care Program reports the following results.

- More than 30% of cancer patients referred to the complex care program have a change in diagnosis, and more than 75% have a significant change made to their treatment plan. Subspecialized expertise and the latest advances in diagnosis and treatment can lead to better outcomes and lower costs for cancer patients. For example, a proton beam therapy program, which precisely destroys cancer while sparing healthy tissue, can reduce the number of treatments for some prostate cancer patients from up to 44 over eight to nine weeks to only five treatments over one to two weeks—resulting in more than $150,000 in savings per patient.
- More than 50% of patients recommended for spine surgery avoid spine surgery after evaluation by the complex care program. This could mean an employer with 100,000 covered lives could achieve cost avoidance of $2 million to $3 million annually.

quently—or not at all—benefit managers are tasked with finding ways to meet employees where they are. Are employees putting off important screenings now that they can't meet a mobile unit in the work parking lot? Benefit managers should look for new ways to incentivize preventive screenings or find alternative ways to bring those screenings to the workforce.

Collective Responsibility

Employers and health care providers have a collective responsibility to ensure that anyone dealing with a complex condition gets the right care at the right time—especially early in their health care journey. By doing so, they can create a positive patient experience, ensure better outcomes and save or control health care costs. BQ

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legal update

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Supreme Court Declines to Hear ERISA Preemption Challenge to Seattle Law

ERISA Industry Committee v. City of Seattle, Washington, No. 21-1019 (9th Cir.) (cert. denied November 30, 2022).
The Supreme Court denied certiorari to review whether an ordinance in Seattle mandating that large hotels offer health insurance coverage or increased pay to their employees is preempted by federal law.

On November 30, 2022, the U.S. Supreme Court declined to hear a case regarding whether a recently enacted law under the City of Seattle's Municipal Code (the Seattle Code) regarding health care expenditures by certain employers was preempted by the Employee Retirement Income Security Act of 1974 (ERISA), specifically under ERISA, 29 USC §§1001–1461. In doing so, the Supreme Court left standing the Ninth Circuit decision that state and local laws governing general health care regulation will generally not be preempted by federal law when operating in a field traditionally occupied by the states.

The city of Seattle Code §14.28 went into effect on July 1, 2020, requiring large hotel employers and ancillary hotel businesses to provide monthly health care payments to ensure employee access to health care services. These payments can be made directly to the employee or to a health insurance program in which the employee is enrolled or can be placed into a health savings or health reimbursement account for the employee.

Employers subject to this law are hotels with more than 100 guest rooms or businesses that operate ancillary hotel services—such as contracting services for hotel purposes, leasing hotel space for hotel purposes, or providing food and beverages within the hotel premises—and that have 50 or more employees. The law covers employees who work for an average of 80 hours or more per month, so long as they are not managers, supervisors or employees working closely with management policies. Employees may waive the right to receive these payments by signing an explicit waiver form, repeatedly declining to accept the monthly payments, alerting their employer they receive health coverage from another source or joining a collective bargaining agreement that expressly waives the benefits. Failure to comply with this law may result in civil fines and penalties levied by the city of Seattle against the employer, at a minimum.

The ERISA Industry Committee (ERIC), an association that advocates on behalf of large employers, sought to stop enforcement of the law. In suing the city of Seattle, ERIC argued that the law was preempted by federal law. *Preemption* is the legal doctrine that allows a federal law to take precedence over a local law. ERISA, established for the purpose of ensuring proper management of funds paid for employee benefit plans and eliminating threats of conflict or inconsistent regulations of employee benefit plans, has a broad preemption clause found in 29 USC §1144(a), establishing exclusive interest in laws relating to employee benefit plans governed by ERISA. Laws that relate to employee benefits plans, for purposes of falling within this preemption clause, are those that have a connection with or reference to an ERISA plan. ERIC argued that Seattle Code §14.28 was preempted by ERISA on three grounds: (1) the law effectively requires the creation of ERISA plans, (2) the law impermissibly references ERISA-covered plans and (3) the law has an impermissible connection with ERISA plans because compliance requires the plans to adopt certain substantive coverage or restrict their choice of insurers.

The U.S. District Court for the Western District of Washington and the Ninth Circuit rejected these arguments, determining instead that the Seattle law does not sufficiently relate to employee benefits to trigger ERISA preemption. Like the district court, the Ninth Circuit relied on its decision in *Golden Gate Restaurant Association v. City and County of San Francisco,* 546 F.3d 639 (9th Cir. 2008). In *Golden Gate,* a similar ordinance requiring employers to make minimum health care payments on behalf of employees was not preempted by ERISA. There, the court found that the law did not sufficiently create, reference or connect with an ERISA plan. The law was not concerned with the nature of the health care benefits provided to employees through certain plans, but instead was concerned with mandating certain amounts of payments, like wages paid to an employee. The law permissibly imposed administrative burdens only upon the employer, not upon the plan. And, finally, the law was not impermissibly connected with an ERISA plan because the employer had the choice of whether to make these required payments to an ERISA plan or another entity.

The Seattle law similarly operates in this field of general health care regulation, a field traditionally occupied by the states. Where the employer can make these payments to either an ERISA plan, a third-party plan or to the employee themselves, the law does not mandate the creation of an ERISA plan. The fact that the Seattle law, unlike the *Golden Gate* law, allowed payments to be made directly to an employee only added further support to this conclusion. Because the employer could provide direct payments to an employee, similar to regular wages, this option was found to be clearly outside the regulation of ERISA and ERISA-covered plans. Therefore, the court concluded the law was not preempted by federal law.

Upon dismissal of the case, ERIC filed a petition for certiorari with the U.S. Supreme Court. In this request for review, the committee emphasized the necessity of ensuring national uniform compliance with ERISA and argued that enforcement of the Seattle law would impose burdensome and location-specific obligations on employers contrary to the purpose of ERISA. ERIC also noted that the Ninth Circuit decision was in direct opposition with two other circuits, the First and the Fourth Circuits. In *Retail Industry Leaders Association v. Fielder,* 475 F.3d 180 (2007), a new law in Maryland required an employer with 10,000 or more Maryland employees to spend 8% of total payroll on its employees' state health insurance costs. The employer also had an option to pay instead an equivalent shortfall to the state. The Fourth Circuit determined that the law was unenforceable, as preempted by ERISA.

As grounds, the Fourth Circuit noted that the law would effectively require employers to restructure their health care plans, therefore conflicting with ERISA's purpose of creating uniform management of these plans. In *Merit Construction Alliance v. City of Quincy,* 759 F.3d 122 (2014), a new ordinance enacted in a city in Massachusetts required that bidders on municipal public works projects operate a Massachusetts-approved apprentice training program subject to a "raft of stringent conditions." The First Circuit concluded that the ordinance impermissibly has a connection with an ERISA plan, namely the apprenticeship program itself which an ERISA welfare plan and therefore the ordinance was preempted. In other words, the ordinance is preempted since, as a condition to bidding, it mandates the structure and administration of an employee benefit welfare program, creating the forbidden connection with the ERISA plan.

Prior to making its determination in the Seattle case, the Supreme Court invited U.S. Solicitor General Elizabeth Prelogar to file a brief. The solicitor general did so, requesting denial of the committee's petition on the grounds that the Seattle law did not have a sufficient connection with or reference to an ERISA-covered plan to require preemption. Prelogar argued that the law mandated payment amounts, regardless of the plan the employee participated in, while offering an opportunity to pay the employee directly without the creation of a plan.

The Court denied ERIC's petition for certiorari on November 30, 2022. In doing so, the Court does nothing to assuage ERIC's concerns about the need for uniformity in the administration of ERISA plans, and leaves states and local lawmakers to rely on the facts distinguishing the Ninth, Fourth and First Circuit decisions as to which programs fall within general health care regulation without impermissibly connecting with or referencing an ERISA-covered plan.

Supreme Court Hears Oral Arguments in FNHRA Violations Case

Health and Hospital Corporation of Marion County v. Talevski, 142 S. Ct. 2673 (2022).

The U.S. Supreme Court is currently reviewing a case on whether a Medicaid beneficiary can claim civil rights violations under 42 USC §1983 (Section 1983) for violations of statutory rights set forth in the Federal Nursing Home Reform Act of 1987 (FNHRA).

On November 8, 2022, the U.S. Supreme Court heard oral arguments on whether a beneficiary of the Medicaid program can claim civil rights violations under Code Section 1983 for violations of rights set forth in FNHRA.

This case originated when Ivanka Talevski, on behalf of her husband, Gorgi Talevski, sued the Valparaiso Care and Rehabilitation facility, a state-run nursing facility in Indiana in which her husband was staying, for civil rights violations

under federal statute Section 1983 because of alleged inadequate medical care. The Talevskis also sued the Health and Hospital Corporation of Marion County (HHC) and the American Senior Communities, LLC (ASC) in this action for the same reasons. Section 1983 enforces existing civil rights and provides a legal remedy to sue state government employees for civil rights violations. It states specifically that an individual who is deprived "of any rights, privileges, or immunities secured by the Constitution and laws," by the state government can sue under this enforcement statute in federal court.

To successfully sue under Section 1983, however, a complainant must provide the particular civil right that is allegedly being violated, whether that is a constitutional right or statutory right. If a Section 1983 claim is brought due to a statutory violation, the statute itself must provide what is referred to as a private right of action, meaning that the complainant has the right to bring a judicial claim under that statute. In this case, Gorgi Talevski alleged a violation of his civil statutory rights under FNHRA.

FNHRA was enacted by Congress under the Spending Clause provision in the U.S. Constitution, which authorizes Congress to spend public money "for the common defense and general welfare of the United States." FNHRA sets forth minimum standards of care that nursing home facilities must adhere to in order to receive federal financial assistance in the Medicaid program. The Medicaid program permits states to provide medical assistance from federally subsidized funds to low-income families and individuals. To receive federal funding, states participating in the program must abide by the program's statutory and regulatory requirements, which include FNHRA. FNHRA, specifically, sets forth requirements relating to the rights of nursing home facility residents, such as the right to be free from chemical restraints imposed for disciplinary or convenience purposes as opposed to treatment and the right not to be transferred or discharged unless certain criteria are satisfied.

In this case, Ivanka Talevski sued the nursing facility for (1) failing to provide Gorgi Talevski with adequate medical care; (2) administering powerful and unnecessary medications for purposes of chemical restraint, which resulted in rapid decline of his physical and cognitive health; (3) discharging and transferring him without the family's consent; (4) refusing to fulfill a judge's order to readmit him to the nursing facility; and (5) maintaining a policy, practice or custom that failed to provide adequate care for him.

The U.S. District Court for the Northern District of Indiana dismissed the action on the basis that the Talevskis did not set forth a proper claim that would allow the courts to provide legal relief.

On appeal to the U.S. Court of Appeals for the Seventh Circuit, Ivanka Talevski abandoned all but two of the above claims—the nursing facility's failure to provide Gorgi Talevski with adequate medical care and over the nursing facility's transfer and discharge process.

The Seventh Circuit disagreed with the district court, finding that it was wrong in dismissing the case for failure to state a claim. Specifically, the Seventh Circuit began its analysis with Supreme Court decisions stating that complainants seeking relief for an alleged violation of a statute through Section 1983 must assert the violation of a federal right, not just federal law. To determine whether a complainant properly pointed to a federal right, the Seventh Circuit looked to whether (1) Congress intended that the provision relied upon to assert the federal right benefits the complainant, (2) the complainant demonstrated that the federal right is not so vague that its enforcement would strain judicial competence and (3) the statute clearly imposes a binding obligation on states.

In this case, the Seventh Circuit found that Congress did indeed intend for the applicable provisions from FNHRA addressing the resident's right to be free from chemical restraints and rights with respect to discharge and transfer procedures to benefit the patient. Furthermore, the Seventh Circuit determined that the Talevskis successfully demonstrated that the federal rights asserted are not vague such that enforcement would strain judicial competence. The rights asserted in the statute are clear and, as the Seventh Circuit stated, according to FNHRA, facilities must not do exactly what the complainant alleged had occurred. With respect to the third factor, the Seventh Circuit found that the asserted rights in the statute are clear; that is, the statute

consists of mandatory language on what facilities must and must not do.

Once the complainant shows that the rights asserted are enforceable under Section 1983, the defendant may rebut by showing that Congress specifically foreclosed a remedy under Section 1983. According to the Seventh Circuit, the nursing facility did not provide a successful rebuttal when claiming that FNHRA forecloses Section 1983 claims because it provides federal and state enforcement schemes. The FNHRA enforcement mechanism that the nursing facility points to deals with the state's obligation to conduct an annual survey of nursing facilities. The survey would reveal whether the facility is out of compliance with the rest of the statute—If it is, the state could terminate the facility's participation in the state's Medicaid program, deny payment to the facility, assess a civil penalty, transfer residents or take other such measures.

The Seventh Circuit rejected the nursing facility's argument because the enforcement mechanisms in FNHRA are not the type of "unusually elaborate, carefully tailored and restrictive enforcement schemes" that would be frustrated by a Section 1983 claim. As the Seventh Circuit explained, the surveys to check for compliance do not address or protect individual rights to be free from chemical restraints or involuntary transfers or discharge and, therefore, do not by themselves constitute an enforcement scheme that would otherwise foreclose a Section 1983 claim.

The Seventh Circuit also points to other circuit courts, including the Third Circuit and Ninth Circuit, that have held that FNHRA does allow a complainant to sue under Section 1983 for alleged civil rights violations.

The Supreme Court agreed to review this case. The United States filed briefs agreeing with the Talevskis that FNHRA creates enforceable individual rights and that the Court should not overrule precedent allowing Section 1983 enforcement of spending clause laws. It distinguished FNHRA from other spending clause enactments enforced through Section 1983. The U.S. also agreed with HHC that FNHRA has specific administrative enforcement mechanisms that have very little application to state facilities such as the one in question in this case. Oral arguments were heard on November 8, 2022.

Underpayment Claim Accrues With First Reduced Benefit Payment

Gragg v. UPS Pension Plan, 55 F.4th 1059 (6th Cir. 2022).
The Sixth Circuit held that the six-year limitations period for an Employee Retirement Income Security Act (ERISA) claim does not expire before the alleged underpayment on which the claim is based. In other words, the Sixth Circuit held that a cause of action accrues when a pension plan first pays a reduced benefit amount, not when the participant receives notice letters from the plan advising of future monthly payment amounts.

On December 16, 2022, the U.S. Court of Appeals for the Sixth Circuit reversed a decision of the U.S. District Court for the Southern District of Ohio that had dismissed a plaintiff's claim asserted under ERISA. In doing so, the Sixth Circuit held that the plaintiff's claim of underpayment by his pension plans accrued only when those plans actually paid him an amount alleged to be less than what was owed. Thus, the six-year statute did not begin to run until the occurrence of the alleged underpayment.

The plaintiff, Ralph Gragg, worked as a driver hauling freight for UPS for five years after working for 26 years for the Overnite Transportation Company before its acquisition by UPS. In 2008, UPS reclassified Gragg's position from nonunion to union, with the effect that the UPS Pension Plan and the UPS Retirement Plan (the plans) would fund his pension. In June 2010, Gragg requested information about his early retirement benefits from the plans. The plans' responses included information about their "Social Security Leveling Option" that "would increase the beneficiary's monthly benefit before age 65 and thereafter reduce it by the amount of his Social Security benefit" to keep Gragg's total monthly benefit "level" throughout his retirement. Gragg selected the leveling option and gave his notice that he would retire on August 1, 2010. On July 12, 2010, each plan sent Gragg a letter stating that after Gragg turned 65, the plans would each reduce his monthly payment by the anticipated amount of his Social Security benefit.

Gragg began receiving his monthly Social Security benefit upon turning 65 in July 2018. On August 1, 2018, each plan reduced the amount of Gragg's monthly pension payments by the amount of his Social Security benefit. However, because both plans did so, Gragg's overall monthly income

declined by twice the amount of his monthly Social Security benefit so that his income did not remain level as he had expected. In response, Gragg brought suit against the plans on November 2, 2020.[1]

In the district court, Gragg argued that the plans miscalculated his benefits by failing to consider that he received only one Social Security retirement check even though he received his pension from two separate plans. Accordingly, Gragg maintained that both plans should not have deducted the value of his monthly benefit. In their defense, the plans argued, among other things, that Gragg's claim was barred by the applicable statute of limitations.

The district court first noted that the plans' choice of law provisions pointed to state law that provided a six-year statute of limitations applicable to ERISA benefits claims. The district court then found that "an ERISA claim accrues, for statute of limitations purposes, after a 'clear and unequivocal repudiation of benefits, whether through formal or informal means.'" Under that standard, the district court reasoned that the notices that the plans sent to Gragg on July 12, 2010 were sufficient to alert him to his alleged injury. This led the district court to conclude that Gragg's "claim began to accrue when each Plan sent him a Notice detailing his monthly payments on July 12, 2010" and "[g]iven the applicable statutes of limitations . . . expired on July 12, 2016" with the end result that Gragg's claim was time-barred.

Gragg appealed the district court decision to the Sixth Circuit, which conducted a de novo review, meaning review as if the case were being heard initially notwithstanding the district court decision. The Sixth Circuit focused on the federal common law rule that the time when an ERISA benefits claim accrues depends on when the plaintiff discovered or should have discovered the injury that is the basis for his claim. Reasoning that Gragg's injury was the claimed underpayment by the plans, the Sixth Circuit found that his claim did not accrue until the first alleged underpayment, which accrued on August 1, 2018. Therefore, the Sixth Circuit concluded that Gragg's claim was timely as he brought it well within the six-year statute of limitations.

The plans set forth two counterarguments. First, they looked to the district court's repudiation analysis and argued that an ERISA benefits claim may accrue upon a clear and unequivocal repudiation of benefits, which the plans claimed their July 2010 letters amounted to. The Sixth Circuit declined to apply a repudiation rule of accrual to Gragg's underpayment claim on the grounds that the repudiation rule applies "in cases where a plan denies the plaintiff's entitlement to benefits altogether" and not to "disputes about the amount of benefits owed."

The plans' second argument was that Gragg should have brought suit in July 2010 to clarify his rights to future benefits under the plans' terms, citing 29 USC §1132(a)(1)(B). The Sixth Circuit responded by pointing out that "[w]hat Gragg had in July 2010 . . . was merely two letters" and that "[a]n ERISA claim based on the letters alone would have rested upon 'contingent future events that may or may not occur as anticipated, or indeed may not occur at all.'" Noting that "Gragg might have died before 2018, or the Plan might have caught its mistake," the Sixth Circuit rejected the plans' second argument because "in July 2010, Gragg's claim almost certainly would not have been ripe, meaning it would not be reviewable in court at that time."

Ultimately, the unanimous Sixth Circuit reversed the district court judgment and remanded the case. The Sixth Circuit concluded its opinion by stating: "The Plan's mistake throughout its briefing is to conflate a concrete 'dispute' with some concrete 'injury.' Gragg was not injured until the Plan allegedly underpaid him; that is when his claim accrued." The upshot of *Gragg v. UPS Pension Plan* is that an ERISA claim for the underpayment of benefits in the Sixth Circuit does not accrue until the claimant suffers an injury by reason of receiving an allegedly deficient benefit payment.

SECURE 2.0 Act Passes

SECURE 2.0 Act of 2022.
The SECURE 2.0 Act of 2022, enacted on December 29, 2022, sets forth several changes affecting retirement plan requirements, with the intent to provide greater coverage and access.

The SECURE 2.0 Act of 2022 was enacted on December 29, 2022, included as part of the 2023 Consolidated Appropriations Act. The law sets forth several significant changes that impact retirement plans, including but not limited to the

requirement that new 401(k) and 403(b) plans (with some exceptions) include automatic enrollment and escalation, the option for plan sponsors to link plan emergency savings accounts to individual account plans and an increase in automatic rollover limits.

Such broad legislation is intended to expand coverage, increase retirement savings, simplify plan rules and generally provide greater access to such plans. It also offers incentives for contributions to retirement plans and allows employers to match contributions to an employee's retirement plan account based on how much they pay in student loans.

For more information on the SECURE 2.0 Act, visit www.finance.senate.gov/imo/media/doc/Secure%202.0_Section%20by%20Section%20Summary%2012-19-22%20FINAL.pdf.

Final Rule Permanently Extends ACA Reporting Deadline

IRS Final Rule to Extend ACA Reporting (December 15, 2022). *The Internal Revenue Service (IRS) issued a final rule permanently extending the deadline to provide Forms 1095-C and 1095-B to individuals. The rule also allows an alternative method of furnishing these forms to individuals for certain providers.*

IRS has finalized regulations addressing information regarding the reporting of health insurance coverage and other related issues under Sections 5000A, 6055 and 6056 of the Internal Revenue Code, effective December 15, 2022. Specifically, providers of minimum essential health insurance coverage and applicable large employers now have an automatic 30-day extension after January 31 to furnish Forms 1095-C and 1095-B to individuals. This rule replaces the need for written applications for extension requests and the IRS Commissioner's ability to prescribe additional procedures for extensions.

The regulations also provide an alternative method for furnishing Form 1095-B to individuals. By this method, the provider must post a "clear and conspicuous notice" on its website informing individuals that they may receive a copy of their form upon request. The notice must be posted by the applicable furnishing deadline; contain an email address, physical address and telephone number; and remain posted on the website until October 15 of the following reporting year. Should such a request be made, the provider must then furnish the form within 30 days of that request. Applicable large employers may also rely on this alternative method, pursuant to the same guidelines, when furnishing Form 1095-C to part-time and nonemployees only.

The regulations make two other notable changes. First, the good-faith reporting relief that once shielded providers from monetary penalties for incomplete or inaccurate Forms 1095-C and 1095-B is no longer available. Relief is instead available for inaccuracies where a provider can show reasonable cause for the error. Second, and finally, the regulations clarified that coverage limited to COVID-19 testing and diagnostic services, as provided for under the Families First Coronavirus Response Act, are not considered "minimum essential coverage" as used in health insurance–related tax law.

Access to ACA Premium Credits Expanded

IRS Notice 2022-41 Guidance (October 11, 2022). *The Internal Revenue Service (IRS) expands access to the Affordable Care Act (ACA) premium tax credit allowing cafeteria plan sponsors to permit employees to revoke family coverage midyear.*

On October 11, 2022, IRS issued Notice 2022-41, which provides for additional election changes for group health plan coverage under a Section 125 cafeteria plan, beginning for elections effective on or after January 1, 2023. Section 125(d)(1) of the Internal Revenue Code defines a *cafeteria plan* as a written plan maintained by an employer under which all participants are employees and under which all participants may choose among two or more benefits consisting of cash and qualified benefits. Prior to this change, cafeteria plans did not permit employees to change their family coverage election midyear.

IRS issued this notice in conjunction with regulations under Section 36B, "which provide that the affordability of an offer of group health plan coverage for a related individual is based on the employee's cost to cover the employee and the employee's related individuals." See §1.36B-2(c)(3)(v)(A)(2); 87 FR 61979 (Oct. 13, 2022).

This change to cafeteria plans will allow an employee to drop one or more family members so that those family members can enroll in a health insurance exchange to take advantage of premium tax credits. To take advantage of the new changes, one or more of the employee's family members must be eligible for a special enrollment period to enroll in a qualified health plan (QHP) through an exchange, or one or more family members, who are already covered, must wish to enroll in a QHP during the exchange's open enrollment period. ACA created the ability to enroll in a QHP through an exchange.

In addition, the change in coverage under the group health plan must correspond to the intended enrollment of the family member(s) in an exchange for new coverage that is effective no later than the day immediately following the last day of the revoked coverage.

These new election changes are optional, meaning that the sponsor is permitted but not required to adopt these changes as a part of its cafeteria plan. The permissible election change events apply only to group health plan coverage that provides minimum essential coverage within the meaning of ACA. Election changes to health flexible spending arrangements (health FSAs) are not permitted as a result of this notice.

An employer that wishes to take advantage of this new opportunity must amend its cafeteria plan on or before the last day of the plan year in which the new elections are allowed. For example, with a plan year that begins in 2023, an amendment may be adopted any time on or before the last day of the plan year that begins in 2024. An amendment may be effective retroactively to the first day of that plan year, however, the plan must operate in accordance with the notice. Furthermore, an employer must inform participants of the amendment. According to the notice, "in no event may an employer amend a cafeteria plan to allow an election to revoke coverage on a retrospective basis."

DOL and PBGC Increase Maximum Amounts for Retirement Plan Civil Penalties

Final Rule on Maximum Civil Penalties Issued by Department of Labor and the Pension Benefit Guaranty Corporation.

The U.S. Department of Labor (DOL) and the Pension Benefit Guaranty Corporation (PBGC) published a final rule on January 12, 2023 issuing new maximum civil penalties for violations with respect to retirement plans for 2023.

In a final rule published on January 12, 2023, DOL and PBGC published inflation-adjusted revised civil penalties for retirement plans. The increased penalty amounts apply to penalties that are assessed after January 15, 2023 and for violations that occurred after November 2, 2015.

Each year, PBGC adjusts the maximum penalty amounts for failure to provide certain notices or other material information. The maximum penalty for single employer defined benefit plans is $2,586 per day following the deadline for a filing, notice or other information. The 2022 amount was $2,400 per day.

Visit www.federalregister.gov/documents/2023/01/12/2023-00499/adjustment-of-civil-penalties-for-inflation to see the final rule.

Endnote

1. Prior to the commencement of Ralph Gragg's suit, the UPS Pension Plan merged with the UPS Retirement Plan. However, for ease of understanding this summary will continue to refer to "the plans" together.

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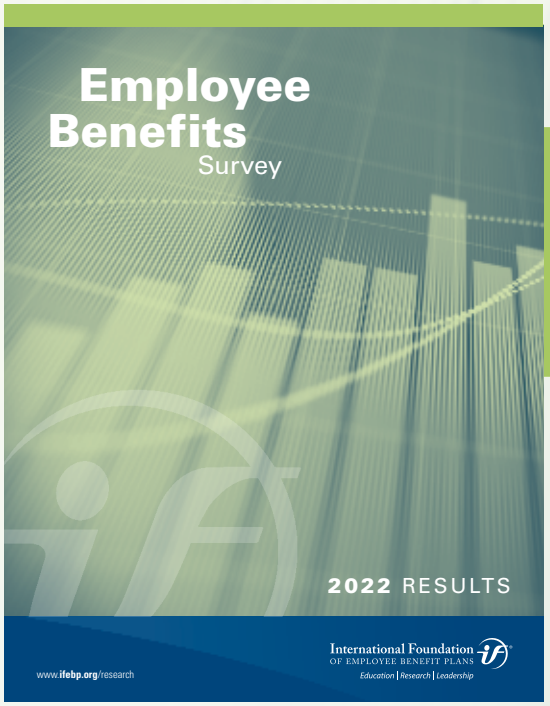

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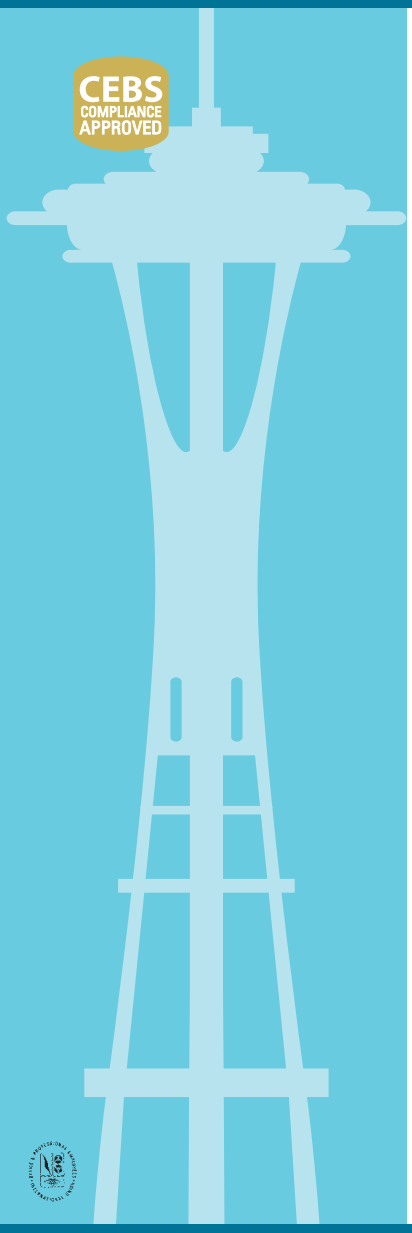

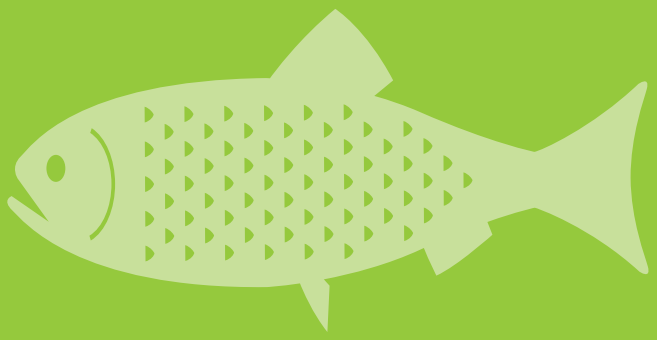

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