LANGBEIN, PRATT, STABILE AND STUMPFF, PENSION AND EMPLOYEE BENEFIT LAW

2021 CUMULATIVE SUPPLEMENT TO THE SIXTH EDITION

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EDITORS' NOTE

This Cumulative Supplement to the 6th Edition covers major developments through mid-August, 2021. The sheer volume of legislation, regulations, other agency publications and case law makes it impossible to cover everything.

We describe briefly the special rules introduced in response to the pandemic. As many of these provisions are of limited duration, we do not think that more extensive coverage is warranted. There are numerous targeted COVID-19 resources available on the websites of law firms and at www.benefitslink.com.

This Supplement was prepared by Sean M. Anderson and David A. Pratt.

Throughout the text, we refer to the numerous limitations on contributions to, and benefits under, various types of tax-favored retirement arrangements. The cost of living adjustments to these limitations appear in the Appendix to this Supplement.

We anticipate that a new (7th) edition will be published in 2022 and edited by Sean Anderson, Kathy Moore and David Pratt. Please feel free to send comments or suggestions to any of us.

We send our best wishes to all our readers, and thank you for your support.

CHAPTER 1
ORIGINS AND FUNDAMENTALS OF THE PENSION SYSTEM

Page 6: at the end of the first full paragraph on the page, add:

These trends appear to be continuing. A 2016 analysis found that employment rates had increased since 2008 among Americans aged 65-69, 70-74, and 75 and above, even as the overall employment rate among all adults had declined. In addition, the percentage of older workers who worked full-time had continued to increase, with only 36.1% working less than 35 hours per week. Drew DeSilver, More Older Americans Are Working, and Working More, than They Used To, Pew Research Center (2016), http://www.pewresearch.org/fact-tank/2016/06/20/more-older-americans-are-working-and-working-more-than-they-used-to/.

Page 7: in the last paragraph on the page, immediately following the citation to *The Economics of Aging*, add:

Some of these trends may have reversed, or at least hesitated, in recent years. One study concluded that, by 2010, as many as forty percent of homeowners over age 65 had mortgages, and that their average loan-to-value ratios had climbed from below thirty percent in 1992 to forty-five percent in 2010. Joint Center for Housing Studies of Harvard University, Housing America's Older Adults: Meeting the Needs of an Aging Population (2014).

Page 7: in the last paragraph on the page, immediately after the citation to the 2013 U.S. Census Bureau report, add:

The 2019 version of the same report placed the poverty rate among those 65 and older at 8.9 percent. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-270.pdf.

Page 18: in Section 2, after citation to Investment Company Institute, add:

By the first quarter of 2021, the total figure had risen to $35.4 trillion, of which IRAs held $12.6 trillion, defined contribution plans $9.9 trillion, private-sector defined benefit plans $3.4 trillion, governmental defined benefit plans $7.1 trillion and annuities $2.5 trillion. Investment Company Institute, U. S. Total Retirement Assets, https://www.ici.org/research/stats/retirement.

Page 20: at the end of the last full paragraph, add:

Statistics from 2016 suggest that older Americans are now deriving a larger portion of their income from work. In that year, 33% of income for those aged 65 and over came from Social Security, while pensions provided 20%, employment earnings 34%, earnings from assets 9%,

and other sources 4%. U.S. Dep't of Health & Human Servs., Admin. For Community Living, 2017 Profile of Older Americans 10, https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2017OlderAmericansProfile.pdf.

Page 34: at the end of the last full paragraph on the page, add:

The 2020 Trustees' Report updates the projections to 2034 for OASI and 2065 for DI. https://www.ssa.gov/oact/tr/2020/. What is the likely effect of the COVID-19 pandemic on Social Security financing? In December 2020, Social Security actuaries released an updated assessment of the program's finances to reflect the impact of the pandemic and ensuing recession, which they describe as significant. "But the impact on Social Security finances appears to be modest. Most of the pandemic/recession effects end by 2025, and the effects on the long-term deficit and on the depletion of the trust fund are negligible." [Alicia H. Munnell, Social Security Actuaries Update Projections for COVID-19, Dec. 8, 2020, *https://www.marketwatch.com/story/social-security-actuaries-update-projections-for-covid-19-2020-12-08*] "Social Security actuaries, on March 17, 2021, concluded that the long-range implications of COVID-19 on Social Security would be "minor," with any pandemic-induced recession recovered by 2023 with "little permanent effect." Over the near term, however, the agency predicts several outcomes that will affect Social Security, including: Lower birth numbers in 2020 and 2021; Higher-than-normal mortality rates in 2020 (12%), 2021 (6%), and 2022 (2%); Disability applications lower in 2020, but higher in 2021 and 2022; Employment reduced in 2020, but fully recovered by 2023; Gross domestic product (GDP), productivity, and earning levels permanently lowered by 1%." [The Pandemic Impact on Social Security & Medicare, updated June 2, 2021, https://www.investopedia.com/the-pandemic-impact-of-social-security-and-medicare-5186940]

CHAPTER 2
DEFINED BENEFIT AND DEFINED CONTRIBUTION PLANS

Page 54: after the first full paragraph, add:

In 2014, President Obama directed Treasury to make available a new, starter IRA, the myRA program. See Richard Eisenberg, *The MyRA Retirement Account Has Finally Arrived*, FORBES (Nov. 4, 2015), https://www.forbes.com/sites/nextavenue/2015/11/04/the-myra-retirement-account-has-finally-arrived/#5b524e5f1ca3. But in July 2017, the Trump Administration announced it was discontinuing the myRA program. Tara Siegel Bernard, *Treasury Ends Obama-Era Retirement Savings Plan*, N.Y. TIMES, (July 28, 2017), https://www.nytimes.com/2017/07/28/business/treasury-retirement-myra-obama.html?partner=rss&emc=rss&smid=tw-nytpolitics&smtyp=cur&_r=1. "Any open *my*RA account in your name has been closed and the balance moved to a new Roth IRA in your name at Retirement Clearinghouse, LLC (RCH), a private sector IRA provider. The RCH accounts are not *my*RA accounts. However, for two years there will be no account maintenance fees or fees associated with withdrawals, transfers, or the closure of your RCH account." [https://myra.gov/]

In November 2015, DoL published a proposed regulation describing a safe harbor for state laws that require employers to facilitate enrollment in state-administered payroll deduction IRAs. State programs that mandate auto-enrollment in IRAs in accordance with the safe harbor would not be treated as ERISA plans. 80 Fed. Reg. 72,006, November 18, 2015. Congress disapproved the rule by joint resolution in 2017. Pub. L. No. 115-35, 131 Stat. 848. "Both the House and Senate recently voted to invalidate regulatory exemptions granted to state retirement plans late in the Obama administration. States are vowing to move ahead regardless, and a political confrontation seems inevitable." [Andrew G. Biggs, How Hard Should We Push the Poor to Save for Retirement?, American Enterprise Institute, July 2017; see also Oregon Board Adopts Final Rules to Implement Retirement Savings Program, May 4, 2017, www.littler.com]

A federal district court has held twice, and the 9th Circuit Court of Appeals affirmed, that California's statute, "CalSavers," is not preempted. Howard Jarvis Taxpayers Ass'n v. CA Secure Choice Retirement Savings Program, 2019 U.S. Dist. LEXIS 54657 (E.D. Cal. 2019); 2020 U.S. Dist LEXIS 41588, 2020 WL 1157924 (E.D. Cal. March 10, 2020); 997 F.3d 848 (9th Cir. 2021). The court reasoned that the statute does not require employers to establish an employee benefit plan; rather, it merely specifies certain effectively administrative consequences for employers who do not do so. For a detailed analysis of such statutes and the arguments for and against their preemption, see Kathryn L. Moore, State Automatic Enrollment IRAs After the Trump Election: Are they Preempted by ERISA? 27 Elder L.J. 51 (2019); see also Edward A. Zelinsky, CalSavers and ERISA: An Analysis of Howard Jarvis Taxpayers Association v. The California Secure Choice Retirement Savings Program, 2019 NYU Review of Employee Benefits and Executive Compensation; Edward A. Zelinsky, CalSavers and ERISA Redux: The District Court's Second Opinion in Howard Jarvis Taxpayers Association v. The California Secure Choice Retirement Savings Program, 2020 NYU Review of Employee Benefits and Executive Compensation; Edward A. Zelinsky, The Ninth Circuit's Jarvis Opinion:

A Correct Application of Retrenched ERISA Preemption, 2021 NYU Review of Employee Benefits and Executive Compensation.

Page 60: after the first, carryover paragraph, add:

The final hybrid plan regulations, which became fully effective January 1, 2017, provide several safe harbor rules under which a cash balance or other hybrid plan benefit formula can be deemed to satisfy the age discrimination requirements applicable to qualified plans. Treas. Reg. 1.411(b)(5)-1.

CHAPTER 3
ORIGINS AND STRUCTURE OF ERISA

Page 77: at the end of Note 6 add:

Application of the prohibited transaction rules to IRAs can be particularly difficult, as the rules were designed with employer plans in mind. The potential sanction is draconian: loss of the IRA's tax exemption. See I.R.C. section 408(e)(2). In Ellis v Commissioner, 787 F. 3d 1213 (2015), the Eighth Circuit affirmed the Tax Court's decision that a taxpayer committed a prohibited transaction when he used his IRA to fund a business that paid him wages.

Page 84: at the end of Note 6, add the following new paragraph:

In June 2017, the Supreme Court resolved a central issue raised in these lawsuits. The Court held that a plan can be a church plan if it is both established and maintained by a church-affiliated organization that is not itself a church; the plaintiffs had argued that a church plan must have been initially established by a church, even if it was later maintained by a different organization. Advocate Health Care Network v. Stapleton, 137 S. Ct. 1652 (2017). It remains for lower courts to sort out whether any particular plan is, in fact, maintained by an organization that meets the statutory criteria—most notably, one that has as its "principal purpose or function … the administration or funding" of the employee benefit plan and that is "controlled by or associated with a church or a convention or association of churches." See ERISA § 3(33)(C)(i). For an example of the follow-on litigation, see Medina v. Catholic Health Initiatives, 877 F.3d 1213 (10th Cir. 2017).

CHAPTER 4
PREVENTING FORFEITURE

Page 117, add at the end of paragraph 9:

Section 112 of the SECURE Act, P. L. 116-94, amends Code section 401(k) to require 401(k) plans to allow long-term part time employees to participate. The plan's service requirement must allow an employee to participate once he or she has performed at least 500 hours of service in each of 3 consecutive 12 month periods. Any permissible minimum age requirement must still be met. The employer is not required to make contributions (including top-heavy contributions) on behalf of such employees, and may treat them as being excludable in testing the plan for coverage and nondiscrimination. The law permits plans to ignore years of service prior to 2021, so no employees will need to be permitted to defer under this provision before 2024.

CHAPTER 5
PLAN AMENDMENT

Page 145: after the first full paragraph, add:

The Consolidated and Further Continuing Appropriations Act of 2014 includes the Multiemployer Pension Reform Act, which authorizes multiemployer plans to suspend benefits for active and retired participants if the plan is in "critical and declining status." See section B.7 in Chapter 6 below. Final regulations provide guidance. 80 Fed. Reg. 35207, Treas. Reg. 1.432(e)(9)-1.

CHAPTER 6

FUNDING AND TERMINATING DEFINED BENEFIT PLANS

Page 165: add after the fifth sentence in the first full paragraph:

With inflation-related increases, the maximum guaranteed benefit was $67,295 for 2019,$69,750 for 2020 and $72,409 for 2021. [https://www.pbgc.gov/wr/benefits/guaranteed-benefits/maximum-guarantee] The maximum is adjusted if payments begin before or after age 65, and if survivor benefits are elected.

Page 172: add after the first paragraph:

Further pension changes were enacted by the Consolidated and Further Continuing Appropriations Act of 2014. The most important changes affect multiemployer plans and appear in the Multiemployer Pension Reform Act which is part of the new law.

The Bipartisan Budget Act of 2015, Pub. L. 114-74, further extended the funding smoothing provisions. The minimum and maximum percentage ranges under IRC § 430(h)(2) were changed to the following:

2012 through 2020	90% to 110%
2021	85% to 115%
2022	80% to 120%
2023	75% to 125%
2024 or later	70% to 130%

The new rules were generally effective for plan years beginning after 2015.

Section 3608 of the CARES Act, enacted in March 2020, delayed until January 1, 2021, the due date of all 2020 required contributions for single-employer plans and allowed plan sponsors to use the prior year's adjusted funding target attainment percentage for 2020. The IRS has clarified that sponsors must pay interest on any delayed contributions. Notice 2020-61, 2020-35 I.R.B. 468, modified by Notice 2020-82, 2020 IRB LEXIS 531, extending the due date to January 4, 2021, the first business day after January 1, 2021.

The American Rescue Plan Act of 2021 provides further funding relief. The Act:

1. Extends the period for amortizing unfunded liabilities from 7 years to 15 years and provides a fresh start of the amortization.
2. Changes the interest rate corridor for determining benefit liabilities from 85% to 115% to 95% to 105% of a 25 year average of prior interest rates and provides that the 25 year average will not be less than 5%.

IRS provided guidance on these changes in Notice 2021-48, https://www.irs.gov/pub/irs-drop/n-21-48.pdf.

Page 180: add after the second full paragraph:

In March, 2017, FASB issued Accounting Standards Update 2017-07, containing guidance on the presentation of net periodic pension and postretirement benefit cost. Under the prior guidance, net benefit cost was reported as an employee cost within operating income (or capitalized when appropriate). The 2017 guidance requires the cost to be bifurcated. The service cost component continues to be included with other employee compensation costs in operating income (or capitalized). The other components are reported separately outside of operations, and are not eligible for capitalization. The change was effective for fiscal years beginning after December 15, 2017, with a 1 year delay for non-public employers.

Page 182: replace the last four sentences of the first paragraph of Note 3 with the following:

The Bipartisan Budget Act of 2015 provided further premium increases. The flat rate premium is $83 for 2020 and $86 for 2021. The supplemental premium for 2021 is $46 per $1,000 of UVBs, with a cap of $582 per participant. See Premium Rates at www.pbgc.gov/prac/prem/premium-rates.html.

Page 183: add at the end of the first paragraph of Note 5:

The maximum guaranteed benefit was $67,295 for 2019 and $69,750 for 2020 and is $72,409 for 2021. The maximum is adjusted if payments begin before or after age 65, and if survivor benefits are elected.

Page 190: at the end of the first paragraph under "Protecting the PBGC", add the following:

For further information, see "Risk Mitigation & Early Warning Questions and Answers", available at https://www.pbgc.gov/prac/risk-migration-q-and-a, and Groom Law Group, PBGC

Walks Back Early Warning Program Expansion, May 11, 2017, https://www.groom.com/resources/pbgc-walks-back-early-warning-program-expansion/.

Page 191: at the end of Note 1, add the following:

By September 30, 2020, PBGC's single-employer insurance program had a positive net position of $15.5 billion. The multiemployer program's deficit, meanwhile, had increased to $63.7 billion, https://www.pbgc.gov/about/faq/pg/deficit-faqs, although that figure was down slightly from a record deficit in 2019 of $65.2 billion, https://www.pbgc.gov/news/press/releases/pr19-12. The small decrease was "primarily due to the enactment of the Bipartisan American Miners Act of 2019, which is expected to help the United Mine Workers of America 1974 Pension Plan avoid insolvency. This development resulted in a delay in the program's projected insolvency from sometime in FY 2025 to sometime in FY 2026." https://www.pbgc.gov/news/press/releases/pr20-06.

"The American Rescue Plan (ARP) Act of 2021, enacted on March 11, 2021, allows certain financially troubled multiemployer plans to apply for special financial assistance. The Pension Benefit Guaranty Corporation (PBGC) created a Special Financial Assistance (SFA) Program. This program addresses the immediate financial crisis threatening the retirement security of over three million American workers, retirees, and their families. The program will provide an estimated $94 billion in assistance to more than 200 eligible plans that are severely underfunded." [https://www.pbgc.gov/american-rescue-plan-act-of-2021]

Page 204: add the following at the end of Note 3:

"The American Rescue Plan (ARP) Act of 2021, enacted on March 11, 2021, allows certain financially troubled multiemployer plans to apply for special financial assistance. The Pension Benefit Guaranty Corporation (PBGC) created a Special Financial Assistance (SFA) Program. This program addresses the immediate financial crisis threatening the retirement security of over three million American workers, retirees, and their families. The program will provide an estimated $94 billion in assistance to more than 200 eligible plans that are severely underfunded." [https://www.pbgc.gov/american-rescue-plan-act-of-2021]

Page 208: revise the last paragraph of Note 3 to read as follows:

British defined benefit plans are required to index pensions in pay status in line with inflation, capped at 5% for benefits accruing from service between April 1997 and April 2005, and at 2.5% for benefits accruing from April 2005. Plans must also revalue the deferred pensions of early leavers in line with inflation capped at 5%, and at 2.5% for rights accrued on or after April 2009.

[House of Commons Library Briefing Paper No. CBP-056056, Occupational Pension Increases, June 21, 2017].

Add the following new Section at the end of the chapter:

D. PENSION DE-RISKING

A defined benefit pension plan represents a very long term commitment for a plan sponsor. Recent developments have made the ongoing cost of the commitment much more difficult to predict: tightened funding rules under the Pension Protection Act of 2006; historically low interest and discount rates; stock market volatility; and general uncertainty as to the strength of the U.S. economy.

In response, many companies have taken steps to reduce their pension risk, and many more are considering doing so: "Five years ago, General Motors and Verizon Communications surprised much of the pension community when they undertook on a grand scale what until then had been a relatively obscure strategy for shedding pension risk: purchasing a group annuity to cover some of their DB plan's pension liabilities. Since those two starter megadeals, the strategy's popularity has surged. In a typical transaction, the plan sponsor transfers to the insurer securities and cash equal in value to the benefit obligation the sponsor wishes to shed. The transfer is usually a portion of the sponsor's total obligation, since shedding the entire obligation at one time could be prohibitively expensive. Once executed, the transaction moves the pension liability from the plan sponsor's balance sheet to the insurer's balance sheet, and the insurer becomes responsible for paying all future pension benefits to plan participants covered by the agreement." [Chris Schmidt, Leaving Pension Management, and Pension Risk, Behind, CFO Magazine, Oct. 3, 2017]

U.S. single premium pension buy-out sales were $4.1 billion in the second quarter of 2017, more than three times higher than the $1.08 billion reported during the same period in 2016. [LIMRA Secure Retirement Institute Quarterly U.S. Group Annuity Risk Transfer Survey, Aug. 31, 2017]. "According to new data shared by the LIMRA Secure Retirement Institute (LIMRA SRI), U.S. single premium pension buyout product sales surpassed $4.7 billion in the first quarter 2019." [https://www.plansponsor.com/prt-transactions-surged-first-quarter-2019/}

Another form of de-risking, which often accompanies an annuity purchase, is giving current pensioners the ability to take a lump sum in lieu of future monthly payments. In 2015, IRS said in Notice 2015-49, 2015-2 C. B. 79, that it intended to amend its current regulations so as generally to prohibit this practice. On March 6, 2019, the IRS issued Notice 2019-18, 2019-13 I.R.B. 915, reversing its previous position that offering a lump-sum option to participants in pay status during a one-time "window" violates section 401(a)(9).

Additional cost concerns driving this activity include changing mortality assumptions to reflect increased longevity; a desire to reduce PBGC premiums by reducing the number of plan participants and the amount of underfunding; and lower corporate tax rates under the 2017 Tax Act. Some pension plans are moving investments from stocks to bonds to realize gains and limit

their exposure to large losses. [Sonali Basak and Katherine Chiglinsky, Pensions Seen Yanking Up To $1 Trillion from Stocks to De-Risk, Pension & Benefits Reporter, 44 BPR 1083, Sept, 5, 2017]

Literature: Advisory Council on Employee Welfare and Pension Benefit Plans, Private Sector Pension De-Risking and Participant Protections, Report to the Secretary of Labor, Nov. 2013; Zorast Wadia, De-risking Your Pension Plan: Do New Regulations Make 2016 the Best Time to Offer Lump-Sum Distributions, Benefits Law Journal, vol. 28, no. 4, winter 2015, 1-9; CFO Research and Mercer, Taking the Next Step in Pension Risk Management, July 2015.

Paul Secunda and Brendan Maher argue that:

> Some de-risking strategies convert a federally-guaranteed pension into a riskier private annuity. Other approaches convert the pension into cash for the beneficiary, which may be insufficient to provide lasting retirement income. These strategies have raised many concerns that participants are being disadvantaged and that pension de-risking is undermining the statutory purpose of ERISA. Regulators are only beginning to consider ways to appropriately police pension de-risking behavior. We propose that the government should take an aggressive stance in regulating such conduct. Participants as a class should not be made worse off by a pension de-risking transaction, and the relevant de-risking rules should so reflect. More specifically, regulators should: (1) encourage desirable forms of de-risking by establishing regulatory safe harbors; (2) require a battery of procedural safeguards for annuitization transactions; (3) require improved disclosures for cash buyouts; and (4) limit cash buyouts when beneficiaries are not likely to meaningfully understand the potentially adverse consequences of trading a pension for cash. [Paul M. Secunda and Brendan S. Maher, Pension De-Risking, 93 Wash. U. L. Rev. 733 (2016)]

A study, Analyzing The Drivers of Pension De-Risking Activity, December 7, 2017, was prepared by Mercer and the Office of the PBGC Participant and Plan Sponsor Advocate. The study states that "The discussion surrounding risk transfer activity involves a number of key drivers. Topping the list of factors influencing plan sponsors' propensity towards risk transfer activity are: Accounting and earnings volatility; Balance sheet liability management; Funding volatility; PBGC premiums."

The study notes that "PBGC flat rate premiums have doubled since 2012, and variable rate premium rates have quadrupled since 2013. As a result, this is an area of particular concern for sponsors, as the magnitude of increase has made this impossible to ignore. Furthermore, there are no indications of a slowing in these escalations, with premium rates in the coming years continuing to be pegged to inflation. Such increases magnify the advantage of undertaking risk transfer activity to reduce plan underfunding and participant headcount as a means of substantially decreasing the ongoing cost of maintaining a pension plan."

The study points out that "The exit of plans- either in full or in part- reduces future premiums and threatens to undermine the ongoing viability of the insurance program. Even worse, it is often plans that are well funded that are more likely to fully terminate or implement risk transfer

strategies, potentially leaving the PBGC to insure an increasingly unhealthy pension universe with a shrinking premium base."

CHAPTER 7

SPOUSAL AND OTHER THIRD-PARTY INTERESTS

Page 226, Note 5:

Change David Clayton Carrad to Patricia Shewmaker and James R. Lewis and change 3d ed. 2010 to 4th ed. 2021.

Page 238: replace the fourth and fifth sentences of the second paragraph with the following:

Other sources of authoritative models include DOL's detailed explanatory booklet, "QDROs: The Division of Retirement Benefits Through Qualified Domestic Relations Orders" (2020) (available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/qdros.pdf). In addition, IRS issued Notice 97-11 [1997-1 CB 379] containing sample language for QDROs. The Notice is included as Appendix C to the DOL booklet. PBGC also has special rules that apply to QDROs affecting terminating defined benefit plans, published in "Qualified Domestic Relations Orders & PBGC" [last updated Feb. 26 , 2021), available from https://www.pbgc.gov/wr/benefits/qdro].

Page 241: add the following at the end of the first full paragraph:

For decisions interpreting these provisions, see Yale-New Haven Hosp. v. Nicholls, 788 F.3d 79 (2d Cir. 2015) and Patterson v Chrysler Group, LLC 845 F.3d 756 (6th Cir. 2017).

Pages 242-243: replace the last full paragraph on page 242 and the next paragraph with the following:

In Obergefell v Hodges, 135 S. Ct. 2584 (2015), the Court held that under the Fourteenth Amendment, same-sex couples have a fundamental right to marry, and so state laws prohibiting same-sex marriage, or refusing to recognize same-sex marriages performed in other jurisdictions, are unconstitutional. Among other ramifications, employers will need to provide QJSAs and QPSAs to same-sex spouses and a domestic relations order with respect to a same-sex spouse can qualify as a QDRO.

Page 244, first full paragraph, add the following at the end:

Roe rejected a claim under section 510 of ERISA. In Schuett v. FedEx Corp., 119 F. Supp. 3d 1155 (N.D. Ca., 2016), the court declined to follow Roe, stating that "The court finds that plaintiff has adequately alleged that FedEx has violated Title I of ERISA by acting contrary to applicable federal law and failing to provide plaintiff with a benefit mandated by ERISA, and

that she is entitled to pursue equitable relief to remedy that violation. The court is not persuaded at this stage of the case and under the facts alleged in the complaint that there is any basis for denying retroactive application of *Windsor*."

Page 254, immediately before Section 3, add the following:

In Sun Life Assurance Co. v Jackson, 877 F.3d 698 (6th Cir. 2017), cert. denied, 2018 U.S. LEXIS 3571 (2018), the Court held that a divorce decree, which provided that the parties were to maintain any employer-related life insurance policies for the benefit of their only child, clearly specified the information required in a QDRO by § 1056(d)(3)(C). The child was therefore entitled to the proceeds of a policy that was sponsored by the child's father's employer, even though another person was named as beneficiary.

Page 257, immediately before Section D:

Change David Clayton Carrad to Patricia Shewmaker and James R. Lewis and change 3d ed. 2010 to 4th ed. 2021.

Page 278: at the end of the last paragraph, add:

In 2016, however, a state appellate court did follow *Egelhoff* in holding Oregon's slayer statute to be preempted. Herinckx v. Sanelle, 385 P.3d 1190 (Or. Ct. App. 2016).

In Laborers' Pension Fund v. Miscevic, 880 F.3d 927 (7th Cir. 2018), the participant was killed by his wife. The wife argued that she was the designated beneficiary and that ERISA preempted the Illinois slayer statute. The district court awarded benefits to the estate, and the Seventh Circuit affirmed, holding that ERISA did not preempt the slayer statute.

Page 280, first full paragraph:

The $1 million cap on the IRA exemption has been increased to $1,362,800. [84 Fed. Reg. 3,488, Feb. 12, 2019]

Page 281: at the end of the first paragraph, add:

For recent limitations on the IRS determination letter program, see section C.3 of chapter 8.

CHAPTER 8

OVERVIEW OF THE TAXATION OF QUALIFIED PLANS

Page 291, insert before Section 3:

New Types of IRA. In 2014, President Obama directed Treasury to make available a new, starter IRA, the myRA program. See www.myRA.gov. DoL opined that myRAs are not ERISA plans. See the December 15, 2014, letter from John J. Canary to J. Mark Iwry, available at https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/information-letters/12-15-2014. In November 2015, DoL published a proposed regulation describing a safe harbor for state laws that require employers to facilitate enrollment in state-administered payroll deduction IRAs. State programs that mandate auto-enrollment in IRAs in accordance with the safe harbor would not be treated as ERISA plans. 80 Fed. Reg. 72,006, November 18, 2015.

In July of 2017, the Trump Administration announced that it was ending the myRA program, on the ground of cost to the federal government. Tara Siegel Barnard, "Treasury Ends Obama-Era Retirement Savings Plan," N.Y. Times, July 29, 2017, p. B2. "Any open *my*RA account in your name has been closed and the balance moved to a new Roth IRA in your name at Retirement Clearinghouse, LLC (RCH), a private sector IRA provider. The RCH accounts are not *my*RA accounts. However, for two years there will be no account maintenance fees or fees associated with withdrawals, transfers, or the closure of your RCH account." [https://myra.gov/]

Page 291: revise the penultimate sentence on the page to read as follows:

For 2021, the maximum contribution to Roth IRAs is phased out for single taxpayers with adjusted gross income between $125,000 and $140,000 and for joint filers with AGI between $198,000 and $208,000. [https://www.irs.gov/retirement-plans/amount-of-roth-ira-contributions-that-you-can-make-for-2021] For 2020, the maximum contribution to Roth IRAs was phased out for single taxpayers with adjusted gross income between $124,000 and $139,000 and for joint filers with AGI between $196,000 and $206,000.

Page 295, first paragraph:

Replace "$183,000 for 2015" with "$198,000 for 2021 and $196,000 for 2020".

Page 297, third paragraph:

Replace "$118,500 for 2015" with "$137,700 for 2020, $142,800 for 2021".

Revise the final sentence by changing "2007" to "2014" and "July 2007" to "April 2015".

Page 301, Note 7:

For 2020, the adjusted gross income thresholds are as follows:

	Married Filing Jointly	Head of Household	All Others
50% credit	$39,500 or less	$29,625 or less	$19,750 or less
20% credit	39,501 to 43,000	29,626 to 32,250	19,751 to 21,500
10% credit	43,001 to 66,000	32,251 to 49,500	21,501 to 33,000
0% credit	More than 66,000	More than 49,500	More than 33,000

[https://www.irs.gov/retirement-plans/plan-participant-employee/retirement-savings-contributions-savers-credit]

Page 305, note 4, add at the end:

Section 112 of the SECURE Act, Pub. L. 116-94, amends Code section 401(k) to require 401(k) plans to allow long-term part time employees to participate. The plan's service requirement must allow an employee to participate once he or she has performed at least 500 hours of service in each of 3 consecutive 12 month periods beginning after 2020.

Page 306, note 11, add at the end:

Beginning in 2020, age 62 is reduced to age 59 ½.

Page 307, note 6, add before the final sentence:

Section 114 of the SECURE Act, Pub. L. 116-94, substitutes age 72 for age 70 ½, effective for distributions required to be made after 2019 with respect to individuals who attain age 70 ½ after December 31, 2019 (i.e., were born after July 1, 1949).

In the case of any defined contribution plan or IRA, the Act also extends the 5 year post-death distribution rule to 10 years, and eliminates the lifetime distribution option for beneficiaries who are not "eligible designated beneficiaries". These new rules generally do not apply to a participant who died prior to January 1, 2020 (2022 for governmental plans).

Page 307, note 8:

The limitation on includible compensation was $270,000 in 2017, $275,000 in 2018, $280,000 in 2019 and $285,000 in 2020 and is $290,000 in 2021.

Page 308, note 12: revise the last two sentences to read as follows:

The qualified plan limitations for 2021 are referred to throughout the text. IRS News Release IR-2020-244, Oct. 26, 2020.

Page 312, insert before Section 5:

IRS has eliminated the five year remedial amendment cycle for individually designed plans. Effective January 1, 2017, the sponsor of an individually designed plan was only able to request a determination letter for initial plan qualification, for qualification on plan termination, or in other limited circumstances. Rev. Proc. 2016-37, 2016-2 C.B. 136. The new procedure also clarified the six-year remedial amendment cycle system for pre-approved plans. Rev. Proc. 2016-37 supersedes Rev. Proc. 2007-44 and modifies Rev. Proc. 2015-36.

On June 30, 2017, IRS issued Rev. Proc. 2017-41, 2017-29 I.R.B. 92. The changes are intended to expand the retirement plan provider market and encourage employers with individually designed plans to convert to a pre-approved plan. The procedure is effective October 2, 2017, and the submission period for the third remedial amendment cycle for providers of pre-approved plans was modified to begin October 2, 2017 and end October 1, 2018 (subsequently extended to December 31, 2018 by Rev. Proc. 2018-42, 2018 IRB LEXIS 466).

The procedure combines the Master and Prototype and Volume Submitter Programs into a single opinion letter program involving standardized plans and non-standardized plans. Adopting employers of non-standardized plans may adopt minor modifications. Standardized plans are more limited with respect to certain plan features. IRS will no longer rule on the exempt status of a pre-approved plan’s trust or custodial account under Code § 501(a).

In April, 2018, IRS issued Notice 2018-24, 2018-17 I.R.B. 507, Request For Comments On Scope Of Determination Letter Program For Individually Designed Plans During Calendar Year 2019. Comments to IRS indicated that the pension community would welcome expansion of the determination letter program.

Rev. Proc. 2019-20, 2019-20 IRB 1182, opens the determination letter program to statutory hybrid plans to apply during a 12-month window beginning on September 1, 2019, and also allows certain merged plans to apply on an ongoing basis. IRS also extended any remedial amendment period still open on the date a plan sponsor becomes eligible to submit a determination letter application until the last day the sponsor may submit a determination letter application under the new guidance.

Page 312: first paragraph under Section 5:

The most recent version of EPCRS is now Rev. Proc. 2021-30, https://www.irs.gov/pub/irs-drop/rp-21-30.pdf. The updated version of EPCRS provides the following:

Expanded guidance regarding the correction of overpayment errors, including new correction methods.

Effective January 1, 2022, the anonymous submission procedure under VCP is eliminated and replaced with an option for a plan representative to request an anonymous, no-fee, pre-submission VCP conference with an IRS representative.

The sunset for the safe harbor correction method available for certain missed elective deferrals for eligible employees who are subject to an automatic contribution feature in a 401(k) or 403(b) plan is extended to December 31, 2023.

Plan sponsors now have three years from the year in which a failure occurs, rather than two, to use SCP to correct significant failures.

Plan sponsors have an expanded ability to correct an operational failure under SCP by plan amendment.

The updated version of EPCRS is generally effective as of July 16, 2021.

Page 312: second paragraph under Section 5:

The reference to Rev. Proc. 2013-12 should now refer to Rev. Proc. 2021-30.

Page 313: third, fifth and seventh paragraphs under Note 1:

The references to Rev. Proc. 2008-50 and Rev. Proc. 2013-12 should now refer to Rev. Proc. 2021-30.

Page 315: first paragraph under Note 3:

The reference to Rev. Proc. 2013-12 should now refer to Rev. Proc. 2021-30.

Page 315: before Section D insert:

4. *Recent Changes to EPCRS.* Rev. Proc. 2015-28, 2015-16 I.R.B. 920, amended EPCRS to allow implementation errors with respect to automatic deferrals to be corrected more easily. Rev. Proc. 2015-27, 2015-16 I.R.B. 914, gave plans more flexibility to correct overpayments to plan participants. These changes are reflected in Rev. Proc. 2016-51, 2016-2 C.B. 466, section 2.04 of which lists the changes made thereby. Rev. Proc. 2016-51 was replaced by Rev. Proc. 2018-52, 2018-42 I.R.B. 611, section 2 of which lists the changes made thereby. Rev. Proc. 2018-52 was replaced by Rev. Proc. 2019-19, 2019-19 I.R.B. 1086, section 2 of which lists the changes made thereby. Rev. Proc. 2019-19 has now been replaced by Rev. Proc. 2021-30,

https://www.irs.gov/pub/irs-drop/rp-21-30.pdf, section 2 of which lists the changes made thereby.

Page 315: first paragraph of Section D:

The limitation on annual benefits under a qualified defined benefit plan has increased to $230,000 for 2020 and 2021 [IRS Notice 2020-79, 2020 IRB LEXIS 505].

Page 322, last full paragraph, add at the end:

In Section 6 of Notice 2020-50, issued under the CARES Act, the Internal Revenue Service states that a coronavirus-related distribution, as defined in the Notice, "will be considered a hardship distribution [under the 401(k) regulations] . . . for purposes of § 1.409A-3(j)(4)(viii)." That section of the regulations allows a nonqualified plan to allow the cancellation of a deferral election following a hardship distribution. Consequently, a nonqualified plan deferral election may be cancelled as a result of a coronavirus-related distribution.

Page 324: before Section 2 insert:

4. *New regulations*. On June 22, 2016, Treasury and the Service published proposed regulations to clarify or modify specific provisions of the final regulations under section 409A. 81 Fed. Reg. 40569. Taxpayers may rely upon the proposed regulations immediately. The preamble explains the government's purpose in revising the regulations: "The Treasury Department and the IRS have concluded that certain clarifications and modifications to the final regulations and the proposed income inclusion regulations will help taxpayers comply with the requirements of section 409A. These proposed regulations address certain specific provisions of the final regulations and the proposed income inclusion regulations and are not intended to propose a general revision of, or broad changes to, the final regulations or the proposed income inclusion regulations. The narrow and specific purpose of these proposed regulations should be taken into account when submitting comments on these proposed regulations."

Page 326, first full paragraph:

The compensation threshold for highly compensated employees remained at $120,000 for 2016, 2017 and 2018 and increased to $125,000 for 2019 and $130,000 for 2020 and 2021. The maximum compensation that can be taken into account under a qualified plan was $275,000 for 2018, $280,000 for 2019, $285,000 for 2020 and is $290,000 for 2021. [IRS Notice 2020-79, 2020 IRB LEXIS 505]

Page 331, first paragraph, add the following at the end:

For plan years beginning after 2019, the SECURE Act, Pub. L. 116-94, has reduced the minimum age for in service distributions from governmental 457(b) plans from 70 ½ to 59 ½.

Page 333, before section E insert:

Regulations. On July 11, 2003, the Treasury Department and the IRS issued final regulations under section 457. 68 Fed. Reg. 41,230. The 2003 final regulations reflected the changes made to section 457 through 2002. In Notice 2007-62, 2007-2 C.B. 331, and at regular intervals since then, Treasury and IRS promised substantive further guidance on areas of uncertainty under section 457. On June 22, 2016, Treasury and IRS published proposed amendments to the regulations under section 457. 81 Fed. Reg. 40,548. The proposed regulations make changes to the 2003 final regulations to reflect statutory changes to section 457 since 2003. In addition, the proposed regulations (1) provide guidance on certain issues under sections 457(e)(11) and 457(e)(12) that are not addressed in the 2003 final regulations and (2) provide additional guidance under section 457(f). The rules under section 457 apply to plan participants and beneficiaries without regard to whether the related services are provided by an employee or independent contractor.

Page 333, second paragraph of Note 1:

The Social Security taxable wage base was $128,400 in 2018, $132,900 in 2019, and $137,700 in 2020 and is $142,800 for 2021.

CHAPTER 9

THE ANTIDISCRIMINATION NORM

Page 349, Note 1, insert:

The compensation threshold for highly compensated status remained at $120,000 for 2016, 2017 and 2018 and increased to $125,000 for 2019 and $130,000 for 2020 and 2021 [IRS Notice 2020-79, 2020 IRB LEXIS 505].

Page 350, Note 1, second paragraph, add at the end:

Section 112 of the SECURE Act, Pub. L. 116-94, amends Code section 401(k) to require 401(k) plans to allow long-term part time employees to participate. The plan's service requirement must allow an employee to participate once he or she has performed at least 500 hours of service in each of 3 consecutive12 month periods beginning after 2020.

Page 355, after Note 3, insert:

4. *Church Plans***.** Section 336 of the Protecting Americans from Tax Hikes (PATH) Act of 2015, Division Q of Pub. L. No. 114-113, clarifies the rules governing church plans, and addresses the application of the controlled group rules to church plans.

Page 365, note 2, add at the end:

Section 205 of the SECURE Act, Pub. L. 116-94, enacts a new Code section 401(o), providing special rules for applying the nondiscrimination rules of section 401(a)(4), and the minimum participation rule of section 401(a)(26), to certain frozen defined benefit plans, to permit existing participants to continue accruing benefits without violating these requirements. The section takes effect on the date of enactment (December 20, 2019), but the plan sponsor may elect that the amendments apply to plan years beginning after 2013.

Page 371, first three paragraphs of Section 3:

The maximum dollar amount of contributions to a defined contribution plan has increased to $56,000 for 2019, $57,000 for 2020 and $58,000 for 2021. The maximum amount of compensation taken into account has increased to $280,000 for 2019, $285,000 for 2020 and $290,000 for 2021 [IRS Notice 2020-79, 2020 IRB LEXIS 505].

In the example on page 372, change $26,500 to $29,000 and $265,000 to $290,000.

Page 373, Note 1:

For 2020, the Social Security taxable wage base was $137,700 and for 2021 it is $142,800.

Page 376, Note 3:

For 2020, the Social Security taxable wage base was $137,700 and for 2021 it is $142,800.
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Page 381, Note 1:

For 2017 and 2018, the compensation threshold for key employees increased from $170,000 to $175,000. For 2019, the threshold was $180,000. For 2020 and 2021, the threshold is $185,000.

Page 383: first full paragraph:

For 2020 and 2021, the dollar limit on elective deferrals is $19,500. The 2019 limit was $19,000. For 2015, 2016 and 2017, the dollar limit was $18,000 and for 2018 it was $18,500. For 2021, the defined contribution maximum has increased to $58,000 ($57,000 in 2020, $56,000 in 2019, $55,000 in 2018).

Page 384, second full paragraph:

The maximum amount of compensation taken into account has increased to $275,000 for 2018, $280,000 for 2019, $285,000 for 2020 and $290,000 for 2021.

Page 385, Note 3, add the following at the end of the first paragraph:

If a 401(k) plan sponsor utilizes a pre-approved document, such as a prototype plan document, and has elected fully discretionary matching contributions, the sponsor must provide the plan administrator (or trustee), written instructions describing (1) how the discretionary matching contribution will be allocated to eligible participants, (2) the computation period(s) to which the discretionary matching contribution formula applies, and (3) if applicable, each business location or business classification subject to separate discretionary matching formulas. The instructions must be provided by the date the plan sponsor funds the discretionary matching contribution. Participants who receive the discretionary matching contribution must be notified of the same items within 60 days following the date the discretionary match is made to the plan. “It is not clear whether these notice requirements also apply to individually-designed plans, but employers that sponsor such plans would be advised to follow the same protocol when approving a discretionary matching contribution, in case this language signals the IRS’s broader expectations for discretionary matches.” [Foley & Lardner, New Requirements for Discretionary 401(k) Plan Matching Contributions, 21 July 2021, https://www.foley.com/en/insights/publications/2021/07/requirements-discretionary-401k-matching]

Page 385, Note 2:

The limit on catch-up contributions remained at $6,000 for 2016, 2017, 2018 and 2019 and increased to $6,500 for 2020 and 2021.

Page 388, Note 5, add at the end:

Section 401(k)(13) describes a "qualified automatic contribution arrangement" (QACA), under which, unless a participant elects otherwise, he or she is automatically enrolled with an employee contribution of at least 3%, increasing gradually to at least 6%. Prior to the SECURE Act, the default percentage could not exceed 10%. Section 102 of the Act increases the cap to 15% (10% for the first plan year of automatic deferrals). This change is effective for plan years beginning after 2019.

Section 103 of the Act limits the annual safe harbor notice required by prior law to plans providing safe harbor matching contributions rather than safe harbor nonelective contributions and modifies the rules governing the timing of plan amendments for employers making safe harbor nonelective contributions under section 401(k)(12) or (13).

Under prior law, safe harbor 401(k) plans that provide a minimum 3% nonelective contribution to participants must provide annual safe harbor notices to covered participants. The Act eliminates the notice requirement. It also permits a 401(k) plan to elect into the 3% nonelective safe harbor at any time until 30 days before the close of the plan year (rather than effectively three months before the close of the year, as previously). The Act also permits a 401(k) plan to elect into the nonelective safe harbor after the 30th day before the close of the plan year if (1) the amendment to adopt the nonelective safe harbor is made by the end of the following plan year, and (2) the nonelective contribution is at least 4%. This change is effective for plan years after 2019.

In July, 2018, IRS issued final regulations allowing the use of forfeitures to fund safe harbor 401(k) plan contributions, qualified matching contributions and qualified non-elective contributions. 83 Fed. Reg. 34,469, July 20, 2018.

Page 388, Note 6:

The limit on SIMPLE deferrals remained at $12,500 for 2016, 2017 and 2018 and increased to $13,000 for 2019 and $13,500 for 2020 and 2021.

Page 388: at the end of the final paragraph of Note 6 insert:

Under section 306 of the Protecting Americans from Tax Hikes (PATH) Act of 2015, Division Q of Pub. L. No. 114-113, rollovers into SIMPLE accounts from other types of retirement plan are permitted.

Page 393, Question 2:

The dollar limits for 2019, 2020 and 2021 are as follows: regular IRA contribution $6,000; SIMPLE plan $13,000 for 2019, $13,500 for 2020 and 2021; the $53,000 limitation has increased to $56,000 for 2019, $57,000 for 2020 and $58,000 for 2021; and the elective deferral limit has increased to $19,000 for 2019 and $19,500 for 2020 and 2021.

CHAPTER 10

LIMITATIONS ON BENEFITS, CONTRIBUTIONS, AND DEDUCTIONS

Page 398, first paragraph:

The limitation on annual additions to a defined contribution plan is $58,000 for 2021 and was $57,000 for 2020, $56,000 for 2019 and $55,000 for 2018. [IRS Notice 2020-79, 2020 IRB LEXIS 505]

Page 398, Note 1:

The exclusion amount continued to be $18,000 for 2016 and 2017, was $18,500 for 2018, $19,000 for 2019 and is $19,500 for 2020 and 2021. [Notice 2020-79, above]

Page 398, Note 2:

The limit on catch-up contributions continued to be $6,000 for 2016 through 2019. For 2020 and 2021, it is $6,500. The limit is still $3,000 for SIMPLE plans.

Page 399, Note 5:

The maximum amount for an eligible deferred compensation plan continued to be $18,000 for 2016 and 2017, was $18,500 for 2018, was $19,000 for 2019 and is $19,500 for 2020 and 2021.

Page 400, Note 6:

The normal IRA maximum continued to be $5,500 for 2016, 2017 and 2018 and is $6,000 for 2019, 2020 and 2021.

Second paragraph: the 2021 phase-out range is $105,000 to $125,000 for a married couple filing jointly ($104,000 to $124,000 for 2020) and $66,000 to $76,000 for a single individual ($65,000 to $75,000 for 2020). If only one spouse is an active participant, the 2021 phase out range for the other spouse is $198,000 to $208,000 ($196,000 to $206,000 for 2020).

Third paragraph: The maximum Roth IRA contribution is phased out between $125,000 and $140,000 for single individuals and heads of household for 2021 ($124,000 to $139,000 for 2020). The phase out range for a married couple filing jointly is $198,000 to $208,000 ($196,000 to $206,000 for 2020).

Page 401, first paragraph under 2:

The maximum annual benefit under a defined benefit plan has increased to $225,000 for 2019 and $230,000 for 2020 and 2021.

Page 410, second paragraph under 4:

The compensation limitation has increased to $280,000 for 2019, $285,000 for 2020 and $290,000 for 2021.

Page 412, Note 3:

The compensation limitation has increased to $280,000 for 2019, $285,000 for 2020 and $290,000 for 2021. The maximum annual benefit under a defined benefit plan has increased to $225,000 for 2019 and $230,000 for 2020 and 2021.

Page 416; change the second paragraph of Note 3 to read as follows:

IRC section 420 was originally enacted in 1990 as a temporary revenue raiser. Can you see why? Extended several times, it is currently scheduled to expire in 2025. Plan surpluses and reversions are discussed in Chapter 6, supra.

Page 419, final paragraph:

The taxable wage base is $137,700 for 2020 and $142,800 for 2021.

Page 420, first two paragraphs:

The elective 401(k) deferral limit was $18,000 for 2017, $18,500 for 2018, $19,000 for 2019 and is $19,500 for 2020 and 2021.

The annual addition limitation has increased to $56,000 for 2019, $57,000 for 2020 and $58,000 for 2021.

CHAPTER 11

TAXATION OF PARTICIPANTS AND BENEFICIARIES

Page 427: at the end of Note 6 insert:

On May 17, 2016, IRS issued final regulations that treat distributions from a Roth account that are made to multiple destinations as a single distribution, effective January 1, 2016, or an earlier date (after September 17, 2014) chosen by the taxpayer. 81 Fed. Reg. 31,165. If payments are made from a designated Roth account to the account owner and also to the owner's Roth IRA or another designated Roth account, in a direct rollover, pre-tax amounts are allocated first to the direct rollover, instead of being allocated pro rata to each destination, as was the prior rule.

Page 427: after Note 7 insert:

8. *IRA Distributions to Charity*. Under IRC section 408(d)(8), certain IRA distributions that are paid to charities are excluded from the IRA owner's adjusted gross income so that the taxpayer gets an income tax benefit even if he or she does not itemize deductions. Section 112 of the Protecting Americans from Tax Hikes (PATH) Act of 2015, Division Q of Pub. L. No. 114-113, makes this provision permanent by deleting the previous expiration date. Under the SECURE Act, P. L. 116-94, the age at which minimum distributions must begin has increased from 70 ½ to 72 for those born after July 1, 1949 and the previous maximum age of 70 ½ for contributions to a regular IRA has been eliminated. However, the minimum age for charitable distributions remains at 70 ½. To the extent that deductible contributions are made after age 70 ½, the amount excluded from gross income for charitable IRA distributions will be reduced.

Page 428: revise the final paragraph of Note 2 to read as follows:

On May 17, 2016, IRS issued final regulations that are effective January 1, 2016, or an earlier date (after September 17, 2014) chosen by the taxpayer. 81 Fed. Reg. 31,165. If payments are made from a designated Roth account to the account owner and also to the owner's Roth IRA or another designated Roth account, in a direct rollover, pre-tax amounts are allocated first to the direct rollover, instead of being allocated pro rata to each destination, as was the prior rule.

Page 430, first full paragraph, paragraph (1):

As explained in more detail in Section F.3 infra, Section 114 of the SECURE Act, Pub. L. 116-94, substitutes age 72 for age 70 ½, effective for distributions required to be made after 2019 with respect to individuals who attain age 70 ½ after December 31, 2019 (i.e., were born after July 1, 1949).

Page 431, Note 5

As explained in more detail in Section F.3 infra, Section 114 of the SECURE Act, Pub. L. 116-94, substitutes age 72 for age 70 ½, effective for distributions required to be made after 2019 with respect to individuals who attain age 70 ½ after December 31, 2019 (i.e., were born after July 1, 1949).

Page 434: at the end of Note 10 insert:

The 2017 Tax Act has extended the period for rolling over plan loan offset amounts until the due date (including extensions) of the participant's federal income tax return for the year of the offset. Code section 402(c)(3)(C).

Page 435: revise the final sentence of Note 12 to read as follows:

The most recent versions appear in Notice 2020-62, 2020 IRB LEXIS 339.

Page 438: at the end of Note 6 insert:

Under section 306 of the Protecting Americans from Tax Hikes (PATH) Act of 2015, Division Q of Pub. L. No. 114-113, rollovers into SIMPLE accounts from other types of retirement plan are permitted.

Page 442, add after the first paragraph:

Section 2202 of the 2020 CARES Act permits 401(k) plans, 403(b) plans, and governmental 457(b) plans to be amended to allow qualified individuals to request certain distributions. Qualified individuals are defined in IRS Notice 2020-50 [2020 IRB LEXIS 261] to include those who are diagnosed with the SARS CoV-2 virus or the COVID-19 disease, or whose spouse or tax dependent is diagnosed with COVID-19, or who experience adverse financial consequences due to certain COVID-19-related events including quarantine, furlough, or layoff, having hours reduced, or unable to work due to lack of child care. This permits Coronavirus-related plan distributions up to $100,000 in the aggregate (determined on a controlled group basis) during 2020. These distributions can be included in income ratably over a three- year period, and are not subject to the additional 10 percent tax under Section 72(t) of the Code, 20 percent mandatory withholding, or the Code Section 402(f) notice requirement. These distributions can be recontributed to an eligible retirement plan within 3 years from the date of the distribution in a direct rollover, if the plan accepts eligible rollover contributions.

The Act also allows plan loans up to the lesser of $100,000 or 100 percent of the vested account balance, during a 180-day period beginning on March 27, 2020 and ending September 22, 2020. The normal 50 percent limit under the prohibited transaction rules will not be enforced for these loans. [EBSA Disaster Relief Notice 2020-01, IRS Notice 2020-50, above]

In addition, qualified individuals with an existing plan loan were permitted to suspend for one year any loan repayments due between March 27, 2020 and December 31, 2020. Future payments on the loan would be appropriately adjusted to reflect the delay and any interest accruing for the period of the delay, and the period of delay would be disregarded in determining the 5-year maximum repayment period and the term of the loan. IRS Notice 2020-23, 2020-18 I.R.B. 742, allows the suspension of loan payments due between April 1, 2020 and July 15, 2020.

Page 443: add at the end of the first paragraph of Note 5:

The 2017 Tax Act extended the period for rolling over plan loan offset amounts until the due date (including extensions) of the participant's federal income tax return for the year of the offset. Code section 402(c)(3)(C).

Page 448, add at the end of the fourth full paragraph:

Section 104 of Division M of the SECURE Act, Pub. L. 116-94, reduces the earliest age an employee can receive in-service benefits from a pension plan (defined benefit or money purchase) from age 62 to age 59½. The change is effective for plan years beginning after December 31, 2019.

Page 451: at the end of the first full paragraph insert:

The Bipartisan Budget Act of 2018 provides that, effective for plan years beginning after 2018, employees experiencing hardship will not be prohibited from contributing to employer plans for six months after receiving a hardship distribution. The Act clarifies that taking all available loans is not required to satisfy the hardship standards. Finally, the Act expands the sources from which employees may take hardship distributions to include QNECs, QMACs, and any investment earnings. Code section 401(k)(14). The Treasury Department has issued final regulations implementing these statutory changes. [84 Fed. Reg. 49,651 (Sept. 23, 2019)]

Page 451, Note 3, add after the second sentence:

Section 104 of Division M of the SECURE Act, Pub. L. 116-94, reduces the earliest age an employee can receive in-service benefits from a governmental 457(b) plan from age 70 ½ to age 59½. The change is effective for plan years beginning after December 31, 2019.

Page 453, before "Special IRA Rules", add:

Section 113 of the SECURE Act, Pub. L. 116-94, adds a new exception for distributions in the case of birth or adoption of a child, up to $5,000. Any such distribution may be repaid. The provision is effective for distributions made after 2019.

Page 456, before the first paragraph of Section 3, add the following:

The minimum distribution rules have been substantially modified by the SECURE Act. Notes 1 through 15 below describe the prior rules, which remain in effect for many individuals. Notes 16 through 18 summarize the new rules and the effective date of the new rules.

Page 463: at the end of Note 5 insert:

In PLR 201628006, July 8, 2016, a state court reformed a beneficiary designation to substitute two trusts for the beneficiary named by the decedent, his estate. IRS ruled that, although the court order changed the beneficiary of the IRA under state law, it could not create a designated beneficiary for purposes of section 401(a)(9).

Page 468: after Note 13 insert:

14. *Pension Cashouts*. Notice 2015-49, 2015-30 I.R.B. 79, informed taxpayers that amendments would be proposed to the 401(a)(9) regulations to address the use of lump sum distributions to replace annuity payments being paid by a DB plan. The amendments were intended to apply as of July 9, 2015, subject to exceptions. On March 6, 2019, the IRS issued Notice 2019-18, 2019-13 I.R.B. 915, reversing its previous position that offering a lump-sum option to participants in pay status during a one-time "window" violates section 401(a)(9).

15. *Missing Participants*. IRS and DoL have recently issued guidance relating to plan sponsors who have been unable to locate participants to whom required minimum distributions are payable. See IRS Memoranda dated October 19, 2017 (401(k) plans) and February 23, 2018 (403(b) plans) and DoL Field Assistance Bulletin 2014-01. See also Susan Harthill, Elizabeth Goldberg and Oluwaseun (Shay) Familoni, Missing and Unresponsive Participants in ERISA Plans: Current Challenges and Recommendations, 2019 NYU Review of Employee Benefits and Executive Compensation; Kathryn L. Moore, Lost and Found: Reuniting Missing Participants and Lost Pensions, 2021 NYU Review of Employee Benefits and Executive Compensation.

A related issue concerns participants who neglect or otherwise fail to cash a plan check until after the year of the check's distribution. The IRS has reaffirmed its view that in such cases the distribution is nonetheless fully taxable in the year of the check's issuance, which – depending on how much time has elapsed – may require the participant to file an amended return. Rev. Rul. 2019-19, I.R.B. 2019-36 (Sept. 3, 2019).

16. *New Rules Enacted by the SECURE Act of 2019.*

[a] The Required Beginning Date

Section 114 of the Act substitutes age 72 for age 70 ½, effective for distributions required to be made after 2019 with respect to individuals who attain age 70 ½ after December 31, 2019 (i.e., were born after July 1, 1949). "Notably, this change to the new required beginning date for RMDs only applies to those individuals who turn 70 ½ in 2020 or later. So even though an individual turning 70 ½ on December 20, 2019 will not yet be 72 in 2020, they will still be required to continue RMDs under the existing rules, and to take an RMD for 2020 (and each year thereafter)." [Kitces, SECURE Act and Tax Extenders Creates Retirement Planning Opportunities And Challenges, December 23, 2019, https://www.kitces.com/blog/secure-act-2019-stretch-ira-rmd-effective-date-mep-auto-enrollment/]

[b] The Distribution Period

In the case of any defined contribution plan or IRA, the Act also extends the 5 year post-death distribution rule to 10 years, and eliminates the lifetime distribution option for beneficiaries who are not "eligible designated beneficiaries". [Section 401(a)(1) of the Act, adding a new Code section 401(a)(9)(H)] Unlike a life expectancy payout, there is no requirement of annual distributions under the10 year rule.

These new rules generally do not apply to a participant who died prior to January 1, 2020 (2022 for governmental plans). In that case, the old rules continue to apply. [Act section 401(b)] However, pre-2020 deaths are not totally exempted. Section 401(b)(5) of the Act provides the following rule, the correct interpretation of which is not clear:

"(5) EXCEPTION FOR CERTAIN BENEFICIARIES

(A) IN GENERAL. If an employee dies before the effective date [i.e., before 2020] then, in applying the amendments made by this section to such employee's designated beneficiary who dies after such date—
(i) such amendments shall apply to any beneficiary of such designated beneficiary; and
(ii) the designated beneficiary [i.e., the dying-post-2019 designated beneficiary of the died-before-2020 participant] shall be treated as an eligible designated beneficiary for purposes of applying section 401(a)(9)(H)(ii) of the Internal Revenue Code of 1986 (as in effect after such amendments)."

The section of section 401(a)(9)(H) referred to is the one providing that, upon the death of an eligible designated beneficiary who was using the life expectancy payout, the 10 year rule becomes applicable.

There is a delayed effective date for collectively bargained plans. [Act section 401(b)]

The changes do not apply to a "qualified annuity" (as defined in section 401(b)(4)(B)) which is a binding annuity contract in effect on the date of enactment and at all times thereafter. [Id.]

"Eligible designated beneficiaries" (as defined below) can elect, within 1 calendar year of the account owner's death, to receive distributions over their lifetime. As under prior law, surviving spouses may elect to defer distributions until the account owner would have attained his or her required beginning date (which will now generally be age 72).

If a defined contribution plan participant or IRA owner dies before the distribution of his or her entire interest, the 5 year period in section 401(a)(9)(B)(ii) is changed to 10 years and that subsection will apply whether or not distributions have begun in accordance with section 401(a)(9)(A). [Code section 401(a)(9)(H), enacted by section 401(a)(1) of the Act]

Section 401(a)(9)(B)(iii), the life expectancy rule, will apply only in the case of an "eligible designated beneficiary". On the death of an eligible designated beneficiary, any balance must be distributed within 10 years. There is a special rule for certain trusts for disabled or chronically ill beneficiaries.

[c] Eligible Designated Beneficiaries

Section 401(a)(2) of the Act adds a new Code section 401(a)(9)(E)(ii), defining an eligible designated beneficiary to mean a designated beneficiary who is

(1) the employee's surviving spouse,

(2) a child of the employee who has not reached majority, typically age 18 under most state laws. However, for this purpose it may mean age 26 if the child has not completed a specified course of education [Code section 401(a)(9)(F)],

(3) disabled, within the meaning of Code section 72(m)(7),

(4) a chronically ill individual, as defined in Code section 401(a)(9)(E)(ii)(IV), or

(5) an individual who is not more than 10 years younger than the employee.

The determination is made as of the date of death of the employee or IRA account owner. If the eligible designated beneficiary is a child then, subject to the provisions of section 401(a)(9)(F), when the child reaches majority any remaining balance must be distributed within 10 years.

[d] How will taxpayers react to repeal of the stretch IRA

The foregoing provisions inhibit or eliminate one previously available form of tax planning, which involved naming as beneficiary a person much younger than the employee, in order to stretch out over as many years as possible the required distribution, and hence income taxation, of account balances (a so-called "stretch IRA").

Clearly, plan participants and IRA owners who have planned to achieve the maximum possible tax deferral through designation of young beneficiaries and use of the stretch IRA technique will need to revise their approach. In many cases, this might lead to more rational plans: maximum deferral is not the only or, in most cases, the major objective of a good financial or estate plan.

The Joint Committee on Taxation has estimated that the SECURE Act provision would generate $15.7 billion in additional tax revenue through 2029. Financial advisors are already considering alternative approaches that will preserve at least some of the benefits of the stretch IRA, including converting the IRA to a Roth IRA or (surprise, surprise) buying life insurance. And some advisors, including IRA guru Ed Slott, argue that eliminating the stretch IRA will actually result in lost revenue, because IRA owners will turn to other, arguably more tax-efficient strategies. [See, e.g., Melanie Waddell, Ed Slott: Killing Stretch IRAs Would Be A Revenue Loser, Thinkadvisor, Sept. 26, 2018, www.thinkadvisor.com] For a detailed discussion of the changes, see Natalie B. Choate, SECURE's Changes to Retirement Plan Distribution Rules Applicable to Participants and Beneficiaries, available at www.ataxplan.com.

[e] Changes That Were Not Enacted

The Retirement Security and Savings Act of 2019 (S. 1431), introduced in the Senate on May 13, 2019 would have increased the age of RMD commencement to 75 in 2030; participants whose aggregate balances under all defined contribution plans and IRAs do not exceed $100,000 would have been exempt from RMDs; the excise tax on a missed RMD would have been reduced; and Roth accounts in employer plans would have been exempted from lifetime RMDs and the incidental death benefit rules.

The Family Savings Act of 2018 (H.R. 6757), passed by the House in September, 2018, would have exempted from RMDs all individuals with $50,000 or less in tax-preferred retirement assets [section 109]. The determination would be made annually. The Joint Committee on Taxation estimated that this exemption would cost $6.2 billion over ten years. [Joint Committee on Taxation, JCX-73-18, Description of H.R. 6757, The 'Family Savings Act Of 2018.' https://www.jct.gov/publications.html?func=startdown&id=5138] "Exempting low balance accounts from RMDs would help millions of older Americans currently subject to these requirements who cannot afford to hire a financial advisor or accountant to assist and who often are coping with various degrees of cognitive decline." [Martin Neil Baily, Benjamin H. Harris, J. Mark Iwry, "RESA" 2019 Legislative Proposals to Improve Retirement Security and Saving, March 2019, https://www.brookings.edu]

(f) Qualified Charitable Distributions

The Act does not change the age at which an individual can make a qualified charitable distribution (QCD) from an IRA, which remains at age 70 ½ "and now creates a unique 1- or 2-year window where IRA distributions may qualify as charitable contributions, but not as RMDs (that haven't yet begun)." [Kitces, SECURE Act And Tax Extenders Creates Retirement

Planning Opportunities And Challenges, December 23, 2019, https://www.kitces.com/blog/secure-act-2019-stretch-ira-rmd-effective-date-mep-auto-enrollment/] The Act also includes "an anti-abuse rule that coordinates post-70 ½ Traditional IRA contributions with QCDs. Under the rule, any QCD will be reduced by the cumulative amount of total post-70 ½ IRA contributions (but not below $0) that have not already been used to offset an earlier QCD. Effectively ensuring that individuals don't just 'recycle' post-70 ½ IRA contributions into subsequent QCDs." [Id.]

17. *New Minimum Distribution Regulations* In November, 2020, IRS issued updated life expectancy and distribution period tables used for purposes of determining minimum required distributions. [85 Fed. Reg. 72, 472, Nov. 12, 2020] The new regulations apply to distribution calendar years beginning on or after January 1, 2022.

18. *Waiver of 2020 Required Minimum Distributions* Section 2203 of the CARES Act provides for the temporary waiver of required minimum distributions in 2020 for qualified employer retirement plans. Notice 2020-51, 2020-29 I.R.B. 73, provides guidance relating to the waiver and [1] permits rollovers of waived required minimum distributions and certain related payments, including an extension of the 60-day rollover period for certain distributions to August 31, 2020; [2] answers questions relating to the waiver of 2020 RMDs; and [3] provides a sample plan amendment that, if adopted, would provide participants a choice whether to receive waived RMDs and certain related payments. The notice also provides transition relief for plan administrators and payors in connection with the change in required beginning date for RMDs under Section 401(a)(9) of the Code pursuant to section 114 of the SECURE Act.

Page 469: at the end of the first (carryover) paragraph insert:

The annual exclusion has been increased to $15,000 for 2019, 2020 and 2021.

Page 470: at the end of Note 1 insert:

The 2017 Tax Act made a most significant change: for the years 2018-2025 the federal exemption amount was raised from $5 million, as adjusted annually for inflation, to $10 million, as adjusted annually for inflation. For 2019, the exemption amount was $11.4 million. It is $11.58 million for 2020 and $11.7 million for 2021. About 15 states with estate or inheritance taxes set the exemption or threshold level lower. For example, in Massachusetts estates up to $1 million are exempt from estate taxation.

CHAPTER 12 FIDUCIARY STATUS

Page 484: at the end of the first full paragraph (the last paragraph of section (b)), add:

Similarly, the Seventh Circuit has held that the president of a corporation who engineered a transaction constituting self-dealing (the sale at an inflated price of shares to an employee stock ownership plan) was a fiduciary, due to his effective personal control over decisions made on behalf of the plan. Chesemore v. Fenkell, 829 F.3d 803, 813-14 (7th Cir. July 21, 2016).

Page 487: at the end of the final sentence of the carryover paragraph at the top of the page, add:

; Carter v. San Pasqual Fiduciary Trust, 2016 U.S. Dist. LEXIS 122311 (C.D. Cal. Feb. 22, 2016) (stock valuation firm).

Pages 488-489: replace the last five paragraphs of Section 7 with the following:

Early in the Obama Administration, DoL became concerned that this definition was too narrow: that it excluded many people and entities who hold themselves out as "financial consultants" or the like, whom a plan might reasonably consider as its own adviser, but whose contact with the plan is not, for example, "regular." Often the interests of such consultants – who are acting essentially as salespersons – conflict with those of their clients, unbeknownst to the latter, as a result of commission-based fee or similar arrangements. In the Department's words, "instead of ensuring that trusted advisers give prudent and unbiased advice in accordance with fiduciary norms, the current regulation erects a multipart series of technical impediments to fiduciary responsibility." Proposed Rules, Department of Labor, Definition of the Term "fiduciary," 80 FR 21927, 21933 (Apr. 20, 2015).

In April 2016, after a six-year process of proposed rules, financial-industry objections, congressional scrutiny, new proposed rules, and additional uproar, the DoL finalized a new rule. Final Rule, Department of Labor, Definition of the Term ''Fiduciary''; Conflict of Interest Rule – Retirement Investment Advice, 81 FR 20946 (Apr. 8, 2016), codified at 29 C.F.R. § 2510.3-21. The final regulation did away with the old restrictions on fiduciary status and swept within the definition of a plan fiduciary anyone who made an "individually-directed recommendation" as to investments for a fee (including a commission). 29 C.F.R. § 2510.3-21(a). Taken by itself, this rule might well have put traditional commission-based retail advisors out of business, or at least out of the business of advising IRAs and ERISA plans under their current business practices. But DoL included in the regulation a new prohibited transaction exemption, referred to as the "best interest contract" or "BIC" exemption, which was intended to allow commission-based advice – conditioned, however, on adherence to a set of investor-protective requirements. Final Rule, Department of Labor, Best Interest Contract Exemption, 81 FR 21002 (Apr. 8, 2016).

The BIC exemption did not assuage the concerns of the financial industry about the viability of its current business model. With Republican and industry criticism of the fiduciary regulation continuing unabated, the Trump Administration allowed some parts of the rule to go into effect in June 2017 but delayed others, first until January 2018 and then until July 2019. The deferred provisions of the rule contained much of the regulation's "teeth," and the rule's ultimate fate and effectiveness remained in a profound state of politically charged uncertainty.

The resolution of that uncertainty ultimately came from the courts. Five separate lawsuits challenging the rule were filed in June 2016. In March 2018, the U.S. Court of Appeals for the Fifth Circuit released a 2-1 decision vacating the rule in its entirety. Chamber of Commerce of United States of Am. v. Dep't of Labor, 885 F.3d 360 (5th Cir. 2018). A few days later, the DoL announced that it would stop enforcing the rule. Sarah O'Brien, *Labor Department Won't Enforce Investor Protection Rule After Court Decision*, CNBC (Mar. 19, 2018, 10:50 AM), https://www.cnbc.com/2018/03/19/dol-shelving-enforcement-of-fiduciary-rule-after-court-decision.html.

In striking down the fiduciary rule, the Fifth Circuit concluded that the rule was inconsistent with the text of ERISA. *Chamber of Commerce*, 885 F.3d at 368-79. Alternatively, the court held that the rule was an unreasonable interpretation of whatever ambiguity the statute might contain. *Id.* at 379-88. The Department of Labor did not seek review in the Supreme Court.

More recently, DoL proposed an exemption to the prohibited transaction rules [85 Fed. Reg. 40,834, July 7, 2020]. The exemption was finalized in December, 2020 and became effective February 16, 2021, albeit with temporary enforcement relief in place until the end of 2021. Prohibited Transaction Exemption 2020-02, Improving Investment Advice for Workers & Retirees, 85 Fed. Reg. 82798 (Dec. 18, 2020) (to be codified at 29 C.F.R. 2550); Press Release, U.S. Dep't of Labor, US Department of Labor Confirms Investment Advice Exemption (Feb. 12, 2021), available at dol.gov/newsroom/releases/ebsa/ebsa20210212.The exemption will be available to a fiduciary who provides nondiscretionary investment advice that results in additional compensation to the fiduciary or an affiliate. It would be needed only if the broker-dealer, RIA or other financial institution (1) is a fiduciary under ERISA and/or the Code and (2) provides non-discretionary investment advice that results in a self-dealing transaction. The PTE is modeled generally after SEC's Regulation BI [84 Fed. Reg. 33,318, July 12, 2019], but there are some differences.

The DoL also issued an amendment to its interpretation of the reinstated 5-part test [85 Fed. Reg. 40,589, July 7, 2020]. Under the 5-part test, an investment advice fiduciary is one who (1) provides advice about investments for a fee or other compensation, (2) on a regular basis, (3) under a mutual understanding, (4) that the advice will form a primary basis for the investment decision, and (5) that the advice is individualized, based upon the investor's particular needs. The DoL expands the scope of the 5-part test by providing a new interpretation of what constitutes a "regular basis." Under the new interpretation, the "regular basis" requirement is met if either:

The adviser had a preexisting advice relationship with the investor, regardless of whether the prior advice was given in connection with retirement assets subject to ERISA and/or the Code or to other assets; or

The adviser establishes a new relationship that is the first step or is anticipated to be the first step in an ongoing advice relationship. Merely executing a sales transaction at the customer's request does not by itself confer fiduciary status unless an ongoing relationship is being established or is contemplated.

Under the new interpretation, rollover recommendations to plan participants would, in most cases, result in fiduciary status under ERISA, because the fiduciary receives additional compensation that the fiduciary would not have received absent the investor accepting the recommendation.

The new interpretation is not a proposal of a new rule. Instead, it is the DOL's interpretation of the 5-part test and is operative now.

CHAPTER 13

FIDUCIARY DUTIES

Page 520: replace the last paragraph of Section 3 with the following:

4. SALES OF STOCK TO ESOPS AND OTHER SINGLE-EMPLOYER PLAN CONFLICTS

Violations of the duty of loyalty are by no means limited to multiemployer plan cases. See, e.g., Chao v. Malkani, 452 F.3d 290 (4th Cir. 2006) (removing single-employer plan trustee for "repeated efforts to plunder the Plan's assets").

Another important and recurring area of concern involving self-dealing concerns the sale of stock to employee stock ownership plans, or "ESOPs." (ESOPs are described in more detail in Section D of the next chapter.) It is not uncommon for the owner or owners of a company to arrange for the company to establish an ESOP for the company's employees, and then to arrange for the ESOP to buy those owners' shares. This is itself not an inherent prohibited transaction, under a special exception set forth in ERISA § 408(e). The exception applies, however, only if the sale is for no more than the shares' fair market value. See ERISA §§ 408(e)(1); 3(18).

DoL harbors a longstanding concern that, despite the statutory requirement, many such sales involve inflated share prices – given the lack of a true arm's-length negotiating partner "across the table" from the stock sellers. For a recent case of this sort in which the Department was ultimately successful in having the selling stockholders held liable for millions of dollars in damages for causing an ESOP to overpay for stock, see Perez v. Bruister, 823 F.3d 250 (5th Cir. 2016). Similarly, see Chesemore v. Fenkell, 829 F.3d 803 (7th Cir. , 2016). Similar, class-action claims have been brought by ESOP participants. See Allen v. GreatBanc Trust Co., 835 F.3d 670 (7th Cir. 2016).

Page 540: at the end of Section 5, insert the following new paragraph:

In Osberg v. Foot Locker, 138 F. Supp. 3d 517 (S.D.N.Y., 2015), affirmed 862 F. 3d. 198 (2nd Cir., 2017), the employer corporation was found, in a class action brought by plan participants under ERISA, to have violated its fiduciary duties by inadequately disclosing the transitional terms of a plan amendment that converted a traditional defined benefit plan into a cash balance plan (a topic discussed in some detail in Section A.2 of Chapter Five, above). The transition involved the imposition of a "wear-away" period that effectively meant that many plan participants would cease, for an extended period, to accrue any new benefits. The Court held that this circumstance had not been adequately disclosed to participants, that this failure amounted to a breach of fiduciary duty, and that as a result class members were entitled to a "reformation" of the plan, which provided the benefits they had been effectively misled into expecting. (See Chapter 16 for further discussion of reformation and other potential remedies available under ERISA.)

Page 544, Section 2: replace the last sentence with the following:

The case law is reviewed in Jayne E. Zanglein, Sean M. Anderson, Brendan S. Maher, Peter K. Stris & Lawrence A. Frolik, ERISA Litigation (6th ed. 2017) §9.III.D.

Page 549: replace the last sentence with the following:

The case law is reviewed in Jayne E. Zanglein, Sean M. Anderson, Brendan S. Maher, Peter K. Stris & Lawrence A. Frolik, ERISA Litigation (6th ed. 2017) §9.III.D.

CHAPTER 14
FIDUCIARY INVESTING

Page 551: just before the carryover sentence at the bottom of the page, add:

In the first quarter of 2021, the total figure had risen to $35.4 trillion, of which IRAs held $12.6 trillion, defined contribution plans $9.9 trillion, private-sector defined benefit plans $3.4 trillion, and governmental defined benefit plans $7.1 trillion. Investment Company Institute, Retirement Assets Total $35.4 Trillion in First Quarter 2021, https://www.ici.org/statistical-report/ret_21_q1. The share of household financial assets represented by retirement assets was 32 percent at the end of March 2021. Id.

Page 577, Note 12, add at the end:

In Thole v. U. S. Bank, 140 S. Ct. 1615 (2020), the Supreme Court, in a 5-4 decision, curtailed the ability of defined benefit plan participants to sue for fiduciary breach. The majority opinion, written by Justice Kavanaugh, found that participants could not challenge plan investments and fees as a fiduciary breach if the plan was overfunded. In dissent, Justice Sotomayor criticized the majority decision as a departure from prior precedent and contended that trust beneficiaries have always had a right to challenge a trustee's management of the trust.

Page 584: at the end of section 2, add the following new paragraphs:

In October 2015, DoL published Interpretive Bulletin 2015-01 [80 Fed. Reg. 65135, codified at 29 C.F.R. 2509.2015-01] which withdraws IB 2008–01 and reinstates the language of IB 94–01. "The Department believes that in the seven years since its publication, IB 2008–01 has unduly discouraged fiduciaries from considering [economically targeted investment]s and [environmental, social, and governance] factors. In particular, the Department is concerned that the 2008 guidance may be dissuading fiduciaries from (1) pursuing investment strategies that consider environmental, social, and governance factors, even where they are used solely to evaluate the economic benefits of investments and identify economically superior investments, and (2) investing in ETIs even where economically equivalent."

In April 2018, DoL published Field Assistance Bulletin 2018-01, sounding a more cautionary tone about economically targeted investments. The Bulletin warns, for example, that "[f]iduciaries must not too readily treat [economic, social, and governance] factors as economically relevant to the particular investment choices at issue.... Rather, ERISA fiduciaries must always put first the economic interests of the plan in providing retirement benefits."

The DoL released a new proposed regulation on 23 June 2020, which was intended to codify the fiduciary standards for selecting and monitoring investments. The proposed rule would have amended certain provisions of the "Investment duties" regulation and would, if finalized, have severely restricted ESG considerations in selecting ERISA plan investments. [85 Fed. Reg. 39,113, June 30, 2020.] The final rule is entitled Financial Factors in Selecting Plan Investments

[85 Fed. Reg. 72,846, Nov. 13, 2020]**.** The final regulation generally follows the proposal but without the focus on environmental, social, and governance investing. "Although the DOL has cleared a path for ERISA fiduciaries to consider 'ESG' factors when making investment decisions and to offer 'ESG' funds in a 401(k)- or 403(b)-type plan, the path remains relatively narrow as the final rule still requires that selection of the investment option be based solely on pecuniary factors (outside of the 'tie-breaker' context).... [D]ecisions with respect to 'ESG' require careful deliberation, balancing of risks, and documentation." [Proskauer, DOL Issues Final "ESG" Rule Restricting ERISA Fiduciary Consideration of Non-Pecuniary Investment Factors, https://www.erisapracticecenter.com/2020/11/dol-issues-final-esg-rule-restricting-erisa-fiduciary-consideration-of-non-pecuniary-investment-factors/]

The new rule was scheduled to take effect in early 2021, but the Biden Administration has suspended enforcement pending a fresh review. Press Release, U.S. Dep't of Labor, U.S. Department of Labor Statement Regarding Enforcement of Its Final Rules on ESG Investments and Proxy Voting by Employee Benefit Plans (Mar. 10, 2021), available at https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/erisa/statement-on-enforcement-of-final-rules-on-esg-investments-and-proxy-voting.pdf.

Page 591, Note 6, second paragraph, revise the last sentence to read as follows:

See, for example, Groom Law Group, ERISA Litigation Trends: Looking Back at 2019 and Forward to 2020 and Beyond, April 1, 2020, https://www.groom.com/resources/erisa-litigation-trends-looking-back-at-2019-and-forward-to-2020-and-beyond/.

Page 592, add the following after the last full paragraph:

In 2021, the Supreme Court granted certiorari in a case addressing the allegations necessary to state a claim for fiduciary breach based on a plan's offering investment options with fees higher than those for comparable alternatives. Hughes v. Northwestern Univ., 2021 WL 2742780 (July 2, 2021) (granting certiorari). In the decision to be reviewed, the Seventh Circuit affirmed dismissal of the plaintiffs' claims. Divane v. Northwestern Univ., 953 F.3d 980 (7th Cir. 2020). Decisions in the Third and Eighth Circuits were potentially more plaintiff-friendly. See Sweda v. Univ. of Pa., 923 F.3d 320 (3d Cir. 2019); Davis v. Wash. Univ. of St. Louis, 960 F.3d 478 (8th Cir. 2020).

Page 596, Note 8, add the following new paragraphs at the end:

One concern with these funds is that, because of their complexity and variety, plan fiduciaries may not adequately understand how a particular fund works in practice. For recent articles, see Are Your Target Date Funds a Prudent Investment? COVID-19 Puts a Spotlight on Fiduciary Choices, Cohen & Buckmann, P.C., Apr. 13, 2020; Personalized Managed Accounts Can Be Better Than Target Date Funds, Russell Investments. July 6, 2020; Choosing Target Date Funds: A Suitability Assessment, J.P. Morgan Asset Management, Feb. 12, 2020.

"Many fiduciaries have selected these funds for their plans without analyzing the alternatives or understanding how they work. A major lawsuit challenging Walgreens' selection of target date funds for its plans, Brown-Davis v. Walgreen Co., was filed last year, claiming that the plan lost $300 million due to the selection and retention of underperforming target date funds for over 10 years. The lawsuit survived a motion to dismiss, but the judge ruled that plaintiffs had standing only to challenge funds in which they had invested. [Brown-Davis v. Walgreen Co., No.1:19cv-053921, N.D. Ill., March 26, 2020] Since the coronavirus pandemic, there have been additional lawsuits filed against Estee Lauder, Quest Diagnostics and Eversource Energy (Northeast Utilities) with claims for damages and equitable relief based on detailed demonstrations of how more appropriate target date fund choices were available. [The cases are Bilello v. Estee Lauder Inc. (S.D.N.Y., filed 6/23/2020), House Johnson v. Quest Diagnostics (No. 2:28cv-07936, D. N.J., filed June 29, 2020) and Garthwait v. Eversource Energy Company (D. Conn., filed June 30, 2020]" [Carol Buckmann, The Changing Frontier Of ERISA Fiduciary Breach Litigation, 2020 New York University Review of Employee Benefits and Executive Compensation]

Page 602, immediately before Section D, add the following:

On December 20, 2019, President Trump signed into law H. R. 1865, The Further Consolidated Appropriations Act, 2020, Pub. L. 116-94. The Act includes, as Division O, the long-pending SECURE (Setting Every Community for Retirement Enhancement) Act, the most important pension legislation since the Pension Protection Act of 2006.

Section 109 of the Act adds a new plan qualification provision as Code section 401(a)(38), which facilitates providing for distributions in annuity form from defined contribution plans. Except as otherwise to be provided in regulations, a defined contribution plan will not cease to be qualified solely by reason of allowing (1) distribution of a lifetime income investment or (2) distribution of a lifetime income investment in the form of a qualified plan distribution annuity contract, if that lifetime income investment is no longer authorized as an investment under the plan. Conforming amendments are made to sections 401(k), 403(b) and 457. A "qualified distribution" means a direct trustee-to-trustee transfer to an eligible retirement plan (as defined in section 402(c)(8)(B), which includes an IRA). The SECURE Act allows both in-service trustee to trustee transfers of annuity contracts to other eligible plans, including IRAs, and the distribution of annuity contracts.

Section 203 amends ERISA section 105 to require annual disclosure to participants and beneficiaries, setting out the lifetime income stream equivalent of the total benefits accrued to date for the participant or beneficiary. The Secretary of Labor was directed to issue a model disclosure and to prescribe assumptions to be used by administrators of individual account plans. The estimates must be provided at least annually and regardless of whether any annuity distribution option is offered under the plan. DOL issued an interim final rule on August 18, 2020. The rule was published in the Federal Register on September 18, 2020, is effective on

September 18, 2021, and will apply to benefit statements furnished after that date. [85 Fed. Reg. 59,132]

The rule addresses the assumptions to be used in preparing the estimates and provides model disclosures that can be used. Use of the model language is not mandatory, but gives plan sponsors greater assurance that they will qualify for liability relief. Additional disclosures are permissible. There are special disclosures for in-plan annuities. The main advantage of the rule, on which DOL has invited comments, is that it is relatively easy to apply. The main disadvantage is that it will often generate lifetime income illustrations that bear little relation to reality, particularly for participants who are not close to retirement.

Section 204 of the Act enacts ERISA section 404(e) to provide a partial safe harbor for annuity selection by fiduciaries of a defined contribution plan. A fiduciary which follows the requirements of the section in selecting an annuity provider will not be liable for any losses due to an insurer's inability to satisfy its financial obligation.

The new Section 404(e) provides that a fiduciary can meet the ERISA prudence requirement when selecting an annuity provider by engaging "in an objective, thorough, and analytical search". Fiduciaries will be required to satisfy two requirements:

1. They must review "the financial capability of [an] insurer to satisfy its obligations" and determine that "at the time of the selection, the insurer is financially capable of satisfying its obligations under the guaranteed retirement income contract". In order to arrive at this conclusion, the fiduciary need only obtain certain written representations from the insurer.

2. The fiduciary must determine that "the cost (including fees and commissions) of the guaranteed retirement income contract offered by the insurer in relation to the benefits and product features" is "reasonable". There is no requirement that a fiduciary select the least expensive option.

The fiduciary must also "periodically review" the continuing appropriateness of its conclusions regarding the financial capability of the insurer. A fiduciary is deemed to perform a periodic review if it receives certain written representations from the insurer annually, unless it receives notice of a change in circumstances or becomes aware of facts that would cause the fiduciary to question the representations.

As under prior law, the selection of a lifetime income solution requires the prudent choice of both the provider and the product offered by that provider.

Because of the widespread practice of benchmarking other plan investments and the prevalence of litigation over plan costs and fees, plan sponsors will need assistance in the difficult task of comparing features, costs and value of retirement income products. The process is made harder because lifetime income contracts are complex, and their features are not standardized.

Page 623: at the end of the chapter, add the following new paragraphs:

In a *per curiam* opinion in Amgen v. Harris, 577 U.S. 308 (2016), the Court underlined the procedural essentiality of the requirement pronounced in *Dudenhoeffer*, quoted above, that "[t]o state a claim for breach of the duty of prudence on the basis of inside information, a plaintiff must plausibly allege an alternative action that the defendant could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it." *Amgen* was presented to the Supreme Court on appeal from the Court of Appeals for the Ninth Circuit, which had determined that, although the plaintiffs' complaint had not met this test, the Court of Appeals could itself readily envision a plausible alternative action – simply removing the employer stock fund from the plan's available investment alternatives – that could have been taken by the plan fiduciary; and so the case could proceed. The Supreme Court would have none of it: The plausible alternative action must have been alleged *by the plaintiffs, in their complaint*. The Court remanded the case to the district court to determine whether the plaintiffs would be allowed to amend their complaint in the case at bar. See also Spokeo, Inc. v Robins, 578 U.S. 856, in which Justice Alito wrote for the majority that the "irreducible constitutional minimum of standing consists of three elements…. The plaintiff must have (1) suffered an injury in fact, (2) that is fairly traceable to the challenged conduct of the defendant, and (3) that is likely to be redressed by a favorable judicial decision."

More recently a federal district court considered what might count as a "plausible alternative action" the defendant could have taken that would not have been "more likely to harm the fund than to help it." In In re Pilgrim's Pride Stock Inv. Plan ERISA Litig., 2016 U.S. Dist. LEXIS 185809 (E.D. Texas, Aug. 19, 2016), adopted by, dismissed by, judgment entered by Patterson v. Pilgrim, 2016 U.S. Dist. LEXIS 185808 (E.D. Tex., Oct. 4, 2016), plan fiduciaries were alleged to have known, based on inside information, that the employer/stock issuer was in financial jeopardy not yet reflected by the market in the stock price. An immediate sale of the plan's employer stock based on this nonpublic information would have been precluded by securities law. The court dismissed the plaintiff's suggestion that the fiduciaries could nonetheless have publicly disclosed the information, then sold: Doing so would have caused a drop in the stock price, thus causing more harm than good to the plan. Alternatively, bringing in an outside, unaffiliated fiduciary to manage the employer stock investment also wouldn't plausibly have helped, because the outside fiduciary would not have been expected to know the worrisome nonpublic information and thus would not have been expected to sell on behalf of the plan. Similar circumstances seem likely to be present in many like cases, almost by definition, and may limit the practical effect of *Dudenhoeffer*.

In general, the *Dudenhoeffer* standard seems to have been difficult for plaintiffs to meet, with courts rejecting a great many claims. See, e.g., Kopp v. Klein, 894 F.3d 214 (5th Cir. 2018) (applying *Dudenhoeffer* and holding that fiduciaries reasonably relied on stock's market price); Yates v. Nichols, 286 F. Supp. 3d 854 (N.D. Ohio 2017) (same); Jander v. Retirement Plans Comm. of IBM, 272 F. Supp. 3d 444 (S.D.N.Y. 2017) (rejecting plaintiffs' claims based on *Dudenhoeffer*'s "plausible alternative action" language).

One exceptional case in which Defendants did not prevail is Retirement Plans Committee of IBM v. Jander, 910 F. 3d 620 (2d Cir. 2018). The Supreme Court granted certiorari in Jander, and

practitioners hoped that it would clarify its more harm than good pleading standard. However, in January, 2020 the Supreme Court vacated and remanded the decision, 140 S. Ct. 592, with instructions for the lower courts to consider whether fiduciaries have a duty to disclose inside information and whether ERISA's duty to disclose conflicts with the securities laws. On remand, the Second Circuit declined to decide any questions not addressed in its earlier opinion and merely reinstated the district court's original judgment. Jander v. Retirement Plans Comm. of IBM, 962 F.3d 85 (2020).

CHAPTER 15
BENEFIT DENIALS

Page 633: after the second sentence of the first paragraph in Section 4, add:

The pattern continues: a similar search on August 16, 2021, revealed 11,137 cases citing *Firestone*.

Page 640: at the end of the first paragraph of note 9, add:

More recently, the Tenth Circuit applied de novo review where the plan administrator failed to disclose the document that granted discretion, and the SPD "said nothing about the existence" of that document. Lyn M. v. Premera Blue Cross, 966 F.3d 1061, 1067 (10th Cir. 2020).

Page 642: at the end of the first full paragraph, add:

To similar effect are Orzechowski v. Boeing Co. Non-Union Long-Term Disability Plan, 856 F.3d 686 (9th Cir. 2017), and Fontaine v. Metro. Life Ins. Co., 800 F.3d 883 (7th Cir. 2015). On the other hand, one Court of Appeals has held that a state rule imposing limits on discretionary clauses (but ultimately permitting them) was preempted by ERISA. Hancock v. Metro. Life Ins. Co., 590 F.3d 1141 (10th Cir. 2009).

Page 643: at the end of the second full paragraph, add:

In 2008, as discussed further in Section 7 below, the Supreme Court rejected such "special burden-of-proof rules," holding that the word "factor" in *Firestone* means "that when judges review the lawfulness of benefit denials, they will often take account of several different considerations of which a conflict of interest is one." Met. Life Ins. Co. v. Glenn, 554 U.S. 105, 116-17 (2008). The Court added that a conflict of interest might "act as a tiebreaker when the other factors are closely balanced" and "should prove more important . . . where circumstances suggest a higher likelihood that it affected the benefits decision . . . ." *Id.* at 117.

Page 673: at the end of the carryover paragraph at the top of the page, add:

For further analysis of the estoppel remedy as applied to ERISA cases, see the discussion of Cigna Corp. v. Amara, 563 U.S> 421 (2011) at Section B.4 of Chapter 16, below.

CHAPTER 16
ENFORCEMENT AND REMEDIES

Page 700: Insert the following at the end of Note 2:

In its most recent ruling on this issue, Montanile v Board of Trustees of the National Elevator Industry Health Benefit Plan, 577 U.S. 136 (2016), the Court held that a plan could enforce an equitable lien by agreement "only against specifically identified funds that remain in the defendant's possession or against traceable items that the defendant purchased with the funds (e.g., identifiable property like a car)."

Page 711: Insert the following at the end of the last paragraph of Note 3:

After trial, the federal district court indeed granted reformation, concluding (apparently without having required specific evidence to be presented to this effect), that "[i]t is simply incredible to believe that any employee would not rely upon a representation that their compensation was growing with their continued service." Osberg v. Foot Locker, Inc., 138 F. Supp. 3d 517, 556, note 28 (S.D.N.Y. 2015), aff'd 862 F. 3d 198 (2nd Cir. 2017). The Ninth Circuit has held that the remedy of reformation (as well as other equitable remedies such as surcharge, estoppel and restitution) may be available where an employer fails adequately to inform pension plan participants that past service will be disregarded under the plan's terms in calculating benefits. Moyle v. Liberty Mutual Retirement Benefit Plan, 823 F.3d 948 (9th Cir. 2016).

Page 714: Insert the following after the first full paragraph:

The Ninth and Third Circuits have upheld anti-assignment clauses in ERISA health plan documents. This position had been previously taken by the First, Second, Fifth, Tenth, and Eleventh Circuits. In Eden Surgical Center v. Cognizant Technology Solutions Corp., 720 Fed. Appx. 862 (9th Cir. 2018), the plan's anti-assignment clause was upheld despite the fact that (i) the plan's representative mistakenly told the healthcare provider that the plan did not contain an anti-assignment provision, and (ii) the plan did not raise the anti-assignment issue during the administrative review process. See also American Orthopedic & Sports Medicine v. Independence Blue Cross Blue Shield, 890 F. 3d 445 (3rd Cir. 2018), leaving open the question whether a valid power of attorney would allow a healthcare provider to make a claim against the plan.

Page 714: Insert the following before Note 2:

In 2020, the Supreme Court held that a participant in an overfunded defined benefit pension plan does not have Article III standing to bring suit over alleged fiduciary breaches that caused loss to the plan, where the plan was restored to overfunded status after the loss. Thole v. U.S. Bank, 140 S. Ct. 1615 (2020).

Page 729: Insert the following at the end of the first full paragraph:

There continues to be a substantial volume of litigation on the attorney fee issue, and the decisions are not always easy to reconcile.

Page 736: Insert the following excerpt, immediately after the heading "G. Statutes of Limitations":

TIBBLE V. EDISON INTL.

575 U.S. 523 (2015).

JUSTICE BREYER delivered the opinion of the Court.

Under the Employee Retirement Income Security Act of 1974, a breach of fiduciary duty complaint is timely if filed no more than six years after "the date of the last action which constituted a part of the breach or violation" or "in the case of an omission the latest date on which the fiduciary could have cured the breach or violation." The question before us concerns application of this provision to the timeliness of a fiduciary duty complaint. It requires us to consider whether a fiduciary's allegedly imprudent retention of an investment is an "action" or "omission" that triggers the running of the 6-year limitations period.

In 2007, several individual beneficiaries of the Edison 401(k) Savings Plan (Plan) filed a lawsuit on behalf of the Plan and all similarly situated beneficiaries (collectively, petitioners) against Edison International and others (collectively, respondents). Petitioners sought to recover damages for alleged losses suffered by the Plan, in addition to injunctive and other equitable relief based on alleged breaches of respondents' fiduciary duties.

The Plan is a defined-contribution plan, meaning that participants' retirement benefits are limited to the value of their own individual investment accounts, which is determined by the market performance of employee and employer contributions, less expenses. Expenses, such as management or administrative fees, can sometimes significantly reduce the value of an account in a defined-contribution plan.

As relevant here, petitioners argued that respondents violated their fiduciary duties with respect to three mutual funds added to the Plan in 1999 and three mutual funds added to the Plan in 2002. Petitioners argued that respondents acted imprudently by offering six higher priced retail-class mutual funds as Plan investments when materially identical lower priced institutional-class mutual funds were available (the lower price reflects lower administrative costs). Specifically, petitioners claimed that a large institutional investor with billions of dollars, like the Plan, can obtain materially identical lower priced institutional-class mutual funds that are not available to a retail investor. Petitioners asked, how could respondents have acted prudently in offering the six higher priced retail-class mutual funds when respondents could have offered them effectively the same six mutual funds at the lower price offered to institutional investors like the Plan?

As to the three funds added to the Plan in 2002, the District Court agreed. It wrote that respondents had "not offered any credible explanation" for offering retail-class, *i.e.*, higher priced mutual funds that "cost the Plan participants wholly unnecessary [administrative] fees," and it concluded that, with respect to those mutual funds, respondents had failed to exercise "the care, skill, prudence and diligence under the circumstances" that ERISA demands of fiduciaries.

As to the three funds added to the Plan in 1999, however, the District Court held that petitioners' claims were untimely because, unlike the other contested mutual funds, these mutual funds were included in the Plan more than six years before the complaint was filed in 2007. As a result, the 6-year statutory period had run.

The District Court allowed petitioners to argue that, despite the 1999 selection of the three mutual funds, their complaint was nevertheless timely because these funds underwent significant changes *within* the 6-year statutory period that should have prompted respondents to undertake a full due-diligence review and convert the higher priced retail-class mutual funds to lower priced institutional-class mutual funds.

The District Court concluded, however, that petitioners had not met their burden of showing that a prudent fiduciary would have undertaken a full due-diligence review of these funds as a result of the alleged changed circumstances. According to the District Court, the circumstances had not changed enough to place respondents under an obligation to review the mutual funds and to convert them to lower priced institutional-class mutual funds.

The Ninth Circuit affirmed the District Court as to the six mutual funds. With respect to the three mutual funds added in 1999, the Ninth Circuit held that petitioners' claims were untimely because petitioners had not established a change in circumstances that might trigger an obligation to review and to change investments within the 6-year statutory period. Petitioners filed a petition for certiorari asking us to review this latter holding. We agreed to do so.

[ERISA Section 413] reads, in relevant part, that "[n]o action may be commenced with respect to a fiduciary's breach of any responsibility, duty, or obligation" after the earlier of "six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation." Both clauses of that provision require only a "breach or violation" to start the 6-year period. Petitioners contend that respondents breached the duty of prudence by offering higher priced retail-class mutual funds when the same investments were available as lower priced institutional-class mutual funds.

The Ninth Circuit, without considering the role of the fiduciary's duty of prudence under trust law, rejected petitioners' claims as untimely under [§413] on the basis that respondents had selected the three mutual funds more than six years before petitioners brought this action. The Ninth Circuit correctly asked whether the "last action which constituted a part of the breach or violation" of respondents' duty of prudence occurred *within* the relevant 6-year period. It focused, however, upon the act of "designating an investment for inclusion" to start the 6-year period. The Ninth Circuit stated that "[c]haracterizing the mere continued offering of a plan option, without more, as a subsequent breach would render" the statute meaningless and could even expose present fiduciaries to liability for decisions made decades ago. But the Ninth Circuit jumped from this observation to the conclusion that *only* a significant change in circumstances

could engender a new breach of a fiduciary duty, stating that the District Court was "entirely correct" to have entertained the "possibility" that "significant changes" occurring "within the limitations period" might require "'a full due diligence review of the funds,'" equivalent to the diligence review that respondents conduct when adding new funds to the Plan.

We believe the Ninth Circuit erred by applying a statutory bar to a claim of a "breach or violation" of a fiduciary duty without considering the nature of the fiduciary duty. The Ninth Circuit did not recognize that under trust law a fiduciary is required to conduct a regular review of its investment with the nature and timing of the review contingent on the circumstances. Of course, after the Ninth Circuit considers trust-law principles, it is possible that it will conclude that respondents did indeed conduct the sort of review that a prudent fiduciary would have conducted absent a significant change in circumstances.

An ERISA fiduciary must discharge his responsibility "with the care, skill, prudence, and diligence" that a prudent person "acting in a like capacity and familiar with such matters" would use. We have often noted that an ERISA fiduciary's duty is "derived from the common law of trusts." In determining the contours of an ERISA fiduciary's duty, courts often must look to the law of trusts. We are aware of no reason why the Ninth Circuit should not do so here.

Under trust law, a trustee has a continuing duty to monitor trust investments and remove imprudent ones. This continuing duty exists separate and apart from the trustee's duty to exercise prudence in selecting investments at the outset. The Bogert treatise states that "[t]he trustee cannot assume that if investments are legal and proper for retention at the beginning of the trust, or when purchased, they will remain so indefinitely." A. Hess, G. Bogert, & G. Bogert, Law of Trusts and Trustees §684, pp. 145-146 (3d ed. 2009) (Bogert 3d). Rather, the trustee must "systematic[ally] conside[r] all the investments of the trust at regular intervals" to ensure that they are appropriate. Bogert 3d §684, at 147-148; *see also* In re Stark's Estate, 15 N. Y. S. 729, 731 (Surr. Ct. 1891) (stating that a trustee must "exercis[e] a reasonable degree of diligence in looking after the security after the investment had been made"); Johns v. Herbert, 2 App. D. C. 485, 499 (1894) (holding trustee liable for failure to discharge his "duty to watch the investment with reasonable care and diligence"). The Restatement (Third) of Trusts states the following:

> "[A] trustee's duties apply not only in making investments but also in monitoring and reviewing investments, which is to be done in a manner that is reasonable and appropriate to the particular investments, courses of action, and strategies involved." §90, Comment *b*, p. 295 (2007).

The Uniform Prudent Investor Act confirms that "[m]anaging embraces monitoring" and that a trustee has "continuing responsibility for oversight of the suitability of the investments already made." §2, Comment, 7B U. L. A. 21 (1995) (internal quotation marks omitted). Scott on Trusts implies as much by stating that, "[w]hen the trust estate includes assets that are inappropriate as trust investments, the trustee is ordinarily under a duty to dispose of them within a reasonable time." 4 A. Scott, W. Fratcher, & M. Ascher, Scott and Ascher on Trusts §19.3.1, p. 1439 (5th ed. 2007). Bogert says the same. Bogert 3d §685, at 156-157 (explaining that if an investment is determined to be imprudent, the trustee "must dispose of it within a reasonable time"); see, *e.g.*, State Street Trust Co. v. DeKalb, 157 N. E. 334, 336 (1927) (trustee was

required to take action to "protect the rights of the beneficiaries" when the value of trust assets declined).

In short, under trust law, a fiduciary normally has a continuing duty of some kind to monitor investments and remove imprudent ones. A plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones. In such a case, so long as the alleged breach of the continuing duty occurred within six years of suit, the claim is timely. The Ninth Circuit erred by applying a 6-year statutory bar based solely on the initial selection of the three funds without considering the contours of the alleged breach of fiduciary duty.

The parties now agree that the duty of prudence involves a continuing duty to monitor investments and remove imprudent ones under trust law. The parties disagree, however, with respect to the scope of that responsibility. Did it require a review of the contested mutual funds here, and if so, just what kind of review did it require? A fiduciary must discharge his responsibilities "with the care, skill, prudence, and diligence" that a prudent person "acting in a like capacity and familiar with such matters" would use. We express no view on the scope of respondents' fiduciary duty in this case. We remand for the Ninth Circuit to consider petitioners' claims that respondents breached their duties within the relevant 6-year period under §413, recognizing the importance of analogous trust law.

Notes

The Supreme Court's decision did not end the Tibble litigation saga. In December, 2016, on remand from the Supreme Court, the 9th Circuit Court of Appeals decided that it would vacate the district court's judgment in favor of the defense. Tibble v Edison International, 843 F. 3d 1187 (9th Cir. 2016). The plaintiffs then prevailed in the district court The plaintiffs then prevailed in the district court. 2017 U.S. Dist. LEXIS 130806 (C.D. Cal. Aug. 16, 2017).

Page 737: Insert the following before the last full paragraph:

A split among the circuits developed over whether a fiduciary can show a plaintiff's "actual" knowledge of a breach merely by proving the plan sponsor distributed to participants the necessary information – by means, for example, of periodic investment reports required under Section 404 of ERISA. In 2020, the Supreme Court held that such distribution is insufficient; the participant must have become aware of the information. Intel Corp. Investment Policy Comm. v. Sulyma, 140 S. Ct. 768 (2020).

Page 743: At the end of the sentence at the end of the first full paragraph, add:

; Mallon v. Trover Solutions, 613 Fed. Appx. 142 (3rd Cir. 2015).

Page 745: Insert the following at the end of Note 6:

Courts do not always require arbitration of ERISA claims. In Munro v. University of Southern California, 2018 U.S. App. LEXIS 20522 (9th Cir. 2018), the Ninth Circuit held that employees alleging an ERISA breach of fiduciary duty claim against their employer, based on the employer's administration of defined contribution plans, may not be compelled to arbitrate their claims under the arbitration clause in their employment contracts, because their claims were brought on behalf of the plans, not on their own behalf.

CHAPTER 17
PREEMPTION

Page 749: Replace the final sentence of Note 7 with the following:

The state laws presumably continue to apply to non-ERISA plans, such as governmental plans. Section 336 of the Protecting Americans from Tax Hikes (PATH) Act of 2015, Division Q of Pub. L. No. 114-113, clarifies the rules governing church plans, and preempts state law, but only with respect to "automatic contribution arrangements" for church plans.

Page 771: Before Heading D, insert new Section 6:

6. *State Automatic Enrollment IRAs*. Recently some states have sought to improve the general level of retirement savings by requiring employers who do not maintain retirement plans to enroll each new employee automatically, subject to voluntary opt-out, in an IRA. A federal district court has held that California's such statute, "CalSavers," is not preempted. Howard Jarvis Taxpayers Ass'n v. CA Secure Choice Retirement Savings Program, 2019 U.S. Dist. LEXIS 54657 (E.D. Cal. 2019). The court reasoned that the statute does not require employers to establish an employee benefit plan; rather, it merely specifies certain effectively administrative consequences for employers who do not do so. For a detailed analysis of such statutes and the arguments for and against their preemption, see Kathryn L. Moore, State Automatic Enrollment IRAs After the Trump Election: Are they Preempted by ERISA? 27 Elder L.J. 51 (2019); see also Edward A. Zelinsky, CalSavers and ERISA: An Analysis of Howard Jarvis Taxpayers Association v. The California Secure Choice Retirement Savings Program, 2019 NYU Review of Employee Benefits and Executive Compensation.

In a second decision in the same case, the court affirmed its previous decision on somewhat different grounds. Howard Jarvis Taxpayers Ass'n v. Cal. Secure Choice Ret. Sav. Program, 443 F. Supp. 3d 1152 (E. D. Ca 2020). See Edward A. Zelinsky, CalSavers and ERISA Redux: The District Court's Second Opinion in Howard Jarvis Taxpayers Association v. The California Secure Choice Retirement Savings Program, 2020 NYU Review of Employee Benefits and Executive Compensation. The 9th Circuit Court of Appeals has affirmed that California's statute is not preempted. Howard Jarvis Taxpayers Ass'n v. CA Secure Choice Retirement Savings Program, 997 F.3d 848 (9th Cir. 2021). See Edward A. Zelinsky, The Ninth Circuit's Jarvis Opinion: A Correct Application of Retrenched ERISA Preemption, 2021 NYU Review of Employee Benefits and Executive Compensation.

For a discussion of whether ERISA's broad preemption provision is constitutional, see Andrew Morrison Stumpff and Elizabeth Y. McCuskey, Is the Preemption Clause of ERISA Unconstitutional?, 2019 NYU Review of Employee Benefits and Executive Compensation.

Page 778, at the end of Note 3, add the following:

In Sun Life Assurance Co. v Jackson, 877 F.3d 698 (6th Cir. 2017), cert. denied, 2018 U.S. LEXIS 3571 (2018), the Court held that a divorce decree, which provided that the parties were to maintain any employer-related life insurance policies for the benefit of their only child, clearly specified the information required in a QDRO by § 1056(d)(3)(C). The child was therefore entitled to the proceeds of a policy that was sponsored by the child's father's employer, even though another person was named as beneficiary.

Page 779: At the end of the first paragraph of Note 5, add:

Note, however, that in 2016 a state appellate court did follow *Egelhoff* to its seeming logical conclusion, in holding Oregon's slayer statute to be preempted by ERISA. Herinckx v. Sanelle, 385 P.3d 1190 (Or. Ct. App. 2016).

Other courts, however, have continued to disagree. In Laborers' Pension Fund v. Miscevic, 880 F.3d 927 (7th Cir. 2018), the participant was killed by his wife. The wife argued that she was the designated beneficiary and that ERISA preempted the Illinois slayer statute. The district court awarded benefits to the estate, and the Seventh Circuit affirmed, holding that ERISA did not preempt the slayer statute.

Page 788: Before Heading F, insert the following:

The Court of Appeals for the Ninth Circuit has held that ERISA does not preempt an employer's claim of fraud, under state law, based on an insurer's alleged premium-padding arrangement. The Depot, Inc. v. Caring for Montana, 915 F.3d 643 (9th Cir. 2019).

4. State Reporting and Disclosure Requirements

In Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016), the Supreme Court was confronted with the application to an ERISA health insurance plan of the State of Vermont's "all payer claims database" statute, which required submission of data about health care costs, prices, utilization and more from all health insurers and other entities that pay for health care services in the state. According to the Court's opinion, at the time of the case almost 20 states had or were implementing similar statutes.

Writing for the majority (Justices Thomas and Breyer separately concurred), Justice Kennedy concluded, quoting from *Egelhoff*, that the statute was preempted insofar as it applied to ERISA plans:

> Vermont's reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon "a central matter of plan administration" and "interferes with nationally uniform plan administration." The State's law and regulation govern plan reporting, disclosure, and – by necessary implication – recordkeeping. These matters are fundamental components of ERISA's regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could

> create wasteful administrative costs and threaten to subject plans to wide-ranging liability. Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.
> Id. at 323..
>
> Justice Ginsburg, writing for herself and Justice Sotomayor, dissented:
>
> Reporting and disclosure are no doubt required of ERISA plans, but those requirements are ancillary to the areas ERISA governs. The Vermont data-collection statute keeps company with the laws considered in *De Buono* and *Dillingham*: It is generally applicable and does not involve "a central matter of plan administration." [Quoting *Egelhoff*.] And [the plaintiff in this case] "failed to provide any details or showing of the alleged burden," instead "arguing only that 'all regulations have their costs.'" [quoting from the Court of Appeals' opinion and the plaintiff's appellate brief].
> Id. at 341-42.

Since the *Gobeille* decision, the Supreme Court has rejected 8-0 a challenge to an Arkansas statute regulating and requiring disclosure of pricing by pharmacy managers. Rutledge v Pharm. Care Mgmt. Ass'n, 141 S. Ct. 474 (2020).

5. STATE "PROMPT-PAY" STATUTES

Several courts have held preempted, to the extent applicable to ERISA plans, state laws that require insurers to pay benefits within a certain number of days of the participant's having submitted a claim. See, for example, Zipperer v. Premera Blue Cross Blue Shield of Alaska, 2016 U.S. Dist. LEXIS 109531 (E.D. Alaska, Aug. 16, 2016), *20; America's Health Ins. Plans v. Hudgens, 742 F.3d 1319 (11th Cir. 2014).

Page 790: Insert the following new entry at the bottom of the left column at the top of the page:

State law requiring that health claim payers report comprehensive data about health care cost, pricing and utilization. Gobeille v. Liberty Mut. Ins. Co., 577 U.S. 312 (2016).

Page 790: Insert the following new entry at the bottom of the right column at the top of the page:

State law regulating conduct of pharmacy benefit managers. Rutledge v Pharm. Care Mgmt. Ass'n, U. S. Supreme Court, 141 S. Ct. 474 (2020)..

CHAPTER 18
EMPLOYMENT LAW AND DISCRIMINATION ISSUES

Page 826: At the end of section 2, insert:

See also Cardelle v. Miami Beach FOP, 2014 U.S. App. LEXIS 22437 (11th Cir. 2014) (concluding that an enhancement of retirement plan benefits that was unavailable to people who had already retired was not age-discriminatory, because the distinction was based on retirement status rather than age).

Page 834: Add the following at the end of the carryover paragraph:

The final hybrid plan regulations, which became fully effective as of January 1, 2017, provide several safe harbor rules under which a cash balance or other hybrid plan benefit formula can be deemed to satisfy the age discrimination requirements applicable to qualified plans. Treas. Reg. 1.411(b)(5)-1.

Page 842: After note 5, insert new note 6:

6. A newer interpretive front has opened over whether discrimination based on transgender status constitutes prohibited sex discrimination. In 2020, the Supreme Court held that it does. Bostock v. Clayton Cty., 140 S. Ct. 1731 (2020).

Page 842, Section C:

Add the following at the end of paragraph 1:

"Although the guidance acknowledges that long COVID is not always a disability, it indicates that an individualized assessment is necessary to determine whether a person's condition or symptoms substantially limit a major life activity. The guidance also provides examples of when long COVID could meet that definition under applicable law." [HHS and DOJ Issue Guidance on 'Long COVID' as a Disability, Jackson Lewis P.C., July 29, 2021]

Page 843: Add the following at the end of Section C:

One specific recurrent issue involving the interplay of employee benefits and the ADA concerns the validity of employer-sponsored "wellness programs," under which employees gain eligibility for more generous employer-provided health insurance subsidies in return for engaging in certain specified behavior, including programs aimed at, for example, weight-loss or smoking cessation, or even for filling out questionnaires about their health status. The EEOC has been concerned that such subsidies, depending on how they are structured, may effectively preclude participation by and therefore discriminate against persons with certain disabilities.

The immediate legal question is whether a wellness program is a "bona fide benefit plan" that falls within the ADA's safe-harbor exception described above. Courts have come out on

different sides of this question. See, for example, Seff v. Broward County, 691 F.3d 1221, 1224 (11th Cir. 2012) (ADA exception applies to wellness plan); EEOC v. Honeywell International, 2014 U.S. Dist. LEXIS 157945 at *5 (D. Minn. Nov. 6, 2014) (denying EEOC's motion for preliminary injunction); EEOC v. Orion Energy Systems, 208 F. Supp. 3d. 989 (E.D. Wis. 2016) (ADA exception does not apply).

In May, 2016, the EEOC issued final regulations describing the circumstances under which it will treat a wellness program as compliant with the ADA. In general, such a program must be "reasonably designed to promote health or prevent disease." To meet this standard, a program cannot require an overly burdensome amount of time for participation, involve unreasonably intrusive procedures, be a subterfuge for violating the ADA or other laws prohibiting employment discrimination, or require employees to incur significant costs for medical examinations. The program must also be fully voluntary, and may not offer as a cost incentive a subsidy greater than 30% of the lowest-cost available health insurance plan alternative. 81 FR 31125 (May 17, 2016).

The AARP sued the EEOC for failing to establish that a 30% incentive does not render a wellness program involuntary. The district court granted summary judgement in favor of AARP and said that it would vacate the EEOC regulations as of January 1, 2019. AARP v United States EEOC, 267 F. Supp. 3d 14 (D. D.C., 2017). In advance of that date the EEOC itself rescinded its existing regulations.

“On January 7, 2021, the EEOC proposed two rules, under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA), designed to clarify what incentives employers may offer employees and their family members for joining employer-sponsored wellness programs. In the 2017 case AARP v. EEOC, the then-existing regulations on employer-sponsored wellness programs were revoked. Since then, employers have lacked guidance on how to structure wellness programs without violating the requirements of both the ADA and GINA that individuals’ disclosures of health information be voluntary. The EEOC’s new rules seek to balance the competing interests. However, given the Biden Administration’s recently issued freeze on proposed rules that have not yet been enacted, employers should not act on the EEOC’s proposed rules yet.” [EEOC proposes new rules on permissible incentives for employer-sponsored wellness programs, https://www.employmentlawwatch.com/2021/02/articles/employment-us/eeoc-proposes-new-rules-on-permissible-incentives-for-employer-sponsored-wellness-programs/]

"Implementing a COVID-19 premium surcharge wellness program to provide an incentive for more plan participants to get vaccinated comes with some compliance challenges. Those challenges depend largely on the design of the program and the administration of it. And, unfortunately, the guidance surrounding wellness programs, particularly from the Equal Employment Opportunity Commission (EEOC), remains less than clear." [Health Plan Premium Surcharges for Those Not Vaccinated for COVID-19? Jackson Lewis P.C. Aug. 10, 2021, https://www.natlawreview.com/article/health-plan-premium-surcharges-those-not-vaccinated-covid-19] See also Morgan Lewis, EEOC Updates Technical Guidance on COVID-19 with Focus on Vaccine Records and Incentives, June 1, 2021,

https://www.morganlewis.com/pubs/2021/06/eeoc-updates-technical-guidance-on-covid-19-with-focus-on-vaccine-records-and-incentives]

Page 848: Replace Section 2 with the following:

2. *Aftermath: The Supreme Court finds a constitutional right to same-sex marriage*. Two years after *Windsor*, in *Obergefell v. Hodges*, 135 S. Ct. 2584 (2015), the Supreme Court held it unconstitutional for states not to extend marriage rights to same-sex couples. Accordingly, the issues discussed in *Windsor*, as well as many other employee-benefits aspects of marriage, will now be relevant in the cases of many more couples, who have the right to be legally recognized as spouses, for every purpose, in every state. Accordingly, plan sponsors – in every instance in which an employee benefit plan refers to "spouses" – must treat all married persons, same-sex or otherwise, according to the same plan provisions.

Page 849: Delete paragraph "b" (Longer-term implications)

CHAPTER 19
HEALTH PLANS AND HEALTH CARE COVERAGE

Page 854, Note 2, add at the end of the first paragraph:

According to the Economic Policy Institute, "Since the onset of the COVID-19 shock to the economy, roughly 6.2 million workers have lost access to health insurance that they previously got through their employer, according to the best measure of net employment change…. It is likely the case that Medicaid is the dominant alternative source of coverage when people have lost ESI in the COVID-19 shock, as Medicaid rolls have likely expanded by more than 4 million since the COVID-19 shock began." [Health insurance and the COVID-19 shock, Aug. 26, 2020, https://www.epi.org/publication/health-insurance-and-the-covid-19-shock/]

Coverage is a major expense for employers, especially those in small businesses, as they deal with the pandemic's economic fallout. Many may face end-of-year renewal deadlines that are harder and harder to afford. Tens of millions of people could lose their job-based insurance by the end of the year, said Stan Dorn, the director of the National Center for Coverage Innovation at Families USA, the Washington, D.C., consumer group. "The odds are we are on track to have the largest coverage losses in our history," he said.

According to a recent article, "While estimates vary, a recent Urban Institute analysis of census data says at least three million Americans have already lost job-based coverage, and a separate analysis from Avalere Health predicts some 12 million will lose it by the end of this year. Both studies highlight the disproportionate effect on Black and Hispanic workers. "We will probably really start to see it during renewal time, November and December," said Mark Hall, the director of health law and policy at Wake Forest University. "That will be when the money really dries up."" [Some Workers Face Looming Cutoffs in Health Insurance, Reed Abelson, New York Times, Sept. 20, 2020, https://www.nytimes.com/2020/09/28/health/covid-19-health-insurance.html]

"Annual premiums for employer-sponsored family health coverage reached $21,342 this year, up 4% from last year, with workers on average paying $5,588 toward the cost of their coverage. The average deductible among covered workers in a plan with a general annual deductible is $1,644 for single coverage. Fifty-five percent of small firms and 99% of large firms offer health benefits to at least some of their workers, with an overall offer rate of 56%." [Kaiser Family Foundation, 2020 Employer Health Benefits Survey, https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/]

Page 870, Note 3, add at the end:

Recent developments affecting COBRA notices include [1] May 2020 revisions to the DOL's model COBRA notices, [2] mandatory extensions to certain COBRA-related deadlines due to the

COVID-19 pandemic, and [3] many class action lawsuits filed over the last few years alleging deficiencies in COBRA notices. See, e.g., Trucker Huss, Keeping COBRA Notices Compliant in an Ever-Changing Landscape, Nov. 24, 2020, https://www.truckerhuss.com/2020/11/keeping-cobra-notices-compliant-in-an-ever-changing-landscape/. For developments under the American Rescue Plan Act, see The End of a (Short) Era: ARPA COBRA Subsidies and the Remaining Action Item for Plan Sponsors, August 9, 2021, https://www.benefitslawadvisor.com/2021/08/articles/cobra-subsidy/the-end-of-a-short-era-arpa-cobra-subsidies-and-the-remaining-action-item-for-plan-sponsors/ and IRS Notice 2021-46, https://www.irs.gov/pub/irs-drop/n-21-46.pdf.

Page 874, add the following immediately before Section D:

13**.** *2020 and 2021 Coronavirus Legislation* The CARES Act allows FSA, HRA and HSA coverage of medical expenses without a prescription and menstrual care products qualify as an eligible expense. The Act also allows telehealth and other remote care treatment below the high deductible health plan deductible without adversely affecting HSA eligibility. Coverage for COVID treatment is allowed but not required. Under the Families First Coronavirus Response Act, as modified by the CARES Act, group health plans (including grandfathered plans and non-ERISA plans) must cover Coronavirus testing and related services for the duration of the public health emergency (currently through January 20, 2021) without cost-sharing, preauthorization or other medical management requirements.

The American Rescue Plan Act of 2021 improves access to and affordability of health coverage through the Marketplace by increasing eligibility for financial assistance to help pay for Marketplace coverage. The new law will lower premiums for most people who currently have a Marketplace health plan and expand access to financial assistance for more consumers. See Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities, March 2021, https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html.

Page 892, add the following after Note 5:

6. *Pharmacy Benefit Managers* In January, 2020, the Supreme Court agreed to accept an appeal filed by the State of Arkansas of a decision by the Eighth Circuit Court of Appeals finding that ERISA expressly preempts the state's maximum allowable cost law ("MAC law"). Such laws change the way in which pharmacy benefit managers ("PBMs") determine the amount a network retail pharmacy is reimbursed for dispensing generic drugs in ways that may result in the pharmacy being reimbursed less than the cost of the drug dispensed. [Rutledge v. Pharm. Care Mgmt. Assn., Supreme Court No. 18-540; Pharm. Care Mgmt. Assn. v. Rutledge, 891 F. 3rd

1109 (8th Cir., 2018)] On December 10, 2020, in an 8-0 decision, the Supreme Court reversed and held that the law was not preempted. Rutledge v Pharm. Care Mgmt. Ass'n, Dec. 10, 2020, Docket No. 18-540. See Ronald Mann, Opinion analysis: Court rejects challenge to states' authority to regulate pharmacy reimbursements, SCOTUSblog (Dec. 13, 2020, 10:09 PM), https://www.scotusblog.com/2020/12/opinion-analysis-court-rejects-challenge-to-states-authority-to-regulate-pharmacy-reimbursements/.

Pages 894-906: Replace Part E with the following:

E. THE AFFORDABLE CARE ACT

1. INTRODUCTION

The big problem with an employment-based coverage system is that many people (approximately 50 million, in the United States, as of 2010) are not covered. You're not covered under such a system, for a start, unless you or someone in your immediate family has a job. Even if a family member does have a job, his or her employer may not provide health insurance, especially if the employer is small. Prior to 2010, whether to provide health insurance was left entirely to the employer, although several measures, such as the COBRA continuation coverage rights and limits on pre-existing condition exclusions described above, had been adopted to limit gaps in employer-provided coverage.

President Obama signed the Patient Protection and Affordable Care Act, Pub. L. 111–148 (ACA), on March 23, 2010, and the Health Care and Education Reconciliation Act, Pub. L. 111–152 (HCERA) on March 30, 2010 (ACA and HCERA are sometimes referred to collectively as the "Act" or ACA). The ACA dramatically changed the health insurance plan landscape, with a series of legal incentives and sanctions intended to encourage employers to provide group health insurance, as well as a system of insurance exchanges intended to make it easier to purchase individual insurance in situations where employer-based coverage is unavailable.

The status of the ACA remained precarious, however – opposed by Republican legislators and others who viewed the legislation as an example of government overreach. Although the Supreme Court upheld the constitutionality of the ACA in 2012 and rejected a serious non-constitutional challenge in 2015, political challenges persisted. In 2017, as detailed below, new legislation was enacted repealing, effective in 2019, a major element of the Act in its original form: the requirement that people secure adequate health insurance coverage for themselves, popularly known as the "individual mandate." Following that repeal, as discussed below, the constitutionality of the entire ACA was again challenged. In addition, President Trump adopted administrative and regulatory policies aimed at further weakening the ACA.

2. THE GENERAL APPROACH

In the multi-year run-up to the ACA, a number of alternatives were advocated for addressing the problem of covering uninsured Americans. One was the so-called "single-payer"

approach adopted in many other countries, where the government would have become responsible for health insurance—an approach that would have effectively ended the role of U.S. employers as a provider of health insurance. This idea was rejected, however, in favor of a system that is, by contrast, at least intended actually to reinforce the centrality of employer-provided plans.

The overall approach of the ACA was originally three-fold:

- First, address the adverse selection problem, whereby health insurance is disproportionately purchased by less healthy individuals, by requiring almost everyone to secure coverage, one way or another, or pay a penalty (the individual mandate). Conversely, policy prohibitions or limitations on pre-existing conditions were disallowed.

- Second, streamline and expand the individual health insurance market, among other things by creating online insurance "exchanges" to facilitate the purchase of individual insurance policies by anyone not covered by an employer plan; by subsidizing (up to 100%) the cost of that purchase for lower-income Americans; and by standardizing the types and levels of insurance coverage available.

- Third, encourage the widest possible adoption of employer-sponsored plans, through a system of incentives for providing such coverage and penalties for large employers' failure to do so.

A major component of the first of these aims, the individual mandate, has been effectively reversed by the tax legislation signed by President Trump in late 2017. O

All other provisions remain in effect, however, including what is for our purposes among the most salient: The "employer mandate," under which large U.S. employers (those with 50 or more employees) are generally faced with a choice either to provide their employees with group health insurance that meets specified minimum requirements, or, alternatively, potentially pay what is effectively a penalty for failing to provide that insurance.

3. THE ACA'S PRINCIPAL ELEMENTS

a. Individual mandate. As originally enacted and in effect through the end of 2018, the ACA contained an "individual shared responsibility" requirement. Under this provision, more commonly known as the "individual mandate," individuals were generally required either to (1) show that they had maintained health insurance each year meeting specified minimum coverage requirements; or (2) pay a tax penalty, generally calculated as a percentage of household income above a specified threshold. The individual mandate was intended to eliminate or at least greatly mitigate the "adverse selection" problem for health insurance, by which elective health insurance is disproportionately purchased by relatively sick individuals, driving up premium prices. As described in more detail below, this provision was repealed as part of tax legislation signed by President Trump in late 2017, effective beginning in 2019.

b. Exchanges. In addition to encouraging purchase of insurance by means of a penalty for failure to do so in the form of the individual mandate, the ACA also aimed to make it

easier for individuals to purchase such insurance by enabling creation of a competitive private health insurance market through online insurance exchanges. The exchanges are designed to serve as marketplaces where consumers can choose among insurance plans whose costs and benefits are easy to compare. The Center for Consumer Information and Insurance Oversight (CCIIO) issued rules outlining a framework that enables states to build exchanges.

Under the ACA, by default the federal government establishes and maintains the exchange for any state that does not do so itself. In 2021, the majority of states – 30 – rely on the federal government to establish and maintain their ACA exchanges; the rest either operate their exchanges themselves or in partnership with the federal government. [https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D]

c. Insurance requirements. Adjunct, to some degree, to the goal of avoiding adverse selection is a need to impose minimum standards on the health insurance policies available for purchase. Otherwise relatively healthy individuals, while forced or encouraged by the ACA's other provisions to purchase *some* form of coverage, could be expected to gravitate toward low-cost policies providing only limited benefits, again forcing up the cost of more meaningful coverage for the relatively less healthy rest of the population. Minimum policy standards – and policy designs' standardization into discrete coverage levels – also help advance the objective of simplifying the alternatives facing insurance consumers.

The policy coverage levels recognized under the ACA are "bronze," "silver," "gold" and "platinum," each of which is defined by reference to the "actuarial value" of health costs covered by the plan. Actuarial value is the percentage paid by a health plan of the total allowed costs of benefits. Differences in the levels of coverage reflect variations in cost-sharing (for example, through levels of co-pay or deductibles), not differences in the underlying benefits. "Total allowed benefit costs" is defined as the anticipated covered medical spending for "essential health benefit" ("EHB") coverage paid by a health plan for a standard population, based on the health plan's cost-sharing rules. EHBs comprise ten categories of benefits (such as, for example, outpatient services, hospitalization, and maternity and newborn care). The Act requires that all policies sold on the individual market and to small groups (inside or outside the exchanges): (1) cover the ten categories of EHBs; (2) meet annual cost-sharing limits when covering EHBs; and (3) meet actuarial value limits for EHB coverage.

The actuarial level of coverage must be 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan and 90 percent for a platinum plan. Insurance sold to individuals and small businesses must be at one of the four actuarial value levels. Plans must also cap the maximum out of pocket costs for enrollees, based on the out of pocket limits for high-deductible health plans that can be paired with a health savings account. While the individual mandate was in effect, most people were required to have insurance at least at the bronze level, or pay a penalty. The Act allows insurers to sell a lower actuarial value catastrophic plan in the non-group market, to individuals who (1) are under age 30 or (2) would otherwise have been

exempt from the individual mandate because available coverage is unaffordable or enrollment in available coverage would be a hardship.

Although insurers are generally not permitted either to deny coverage or modulate pricing based on pre-existing conditions or demographic characteristics, insurers may vary their rates based on age, tobacco use, family size, and geographical differences. [78 Fed. Reg. 13406] In particular, insurers may charge tobacco users 50 percent more than non-users, with an exemption for those who participate in smoking cessation programs. The Act limits premiums for older people to three times what younger people are charged. The rule prohibits premium rate variation for individuals under age 21, and allows insurers to charge slightly more annually until a person reaches age 64. Above age 64, all enrollees must pay the same rate.

The Act also contains certain specific coverage requirements, including recommended preventive health services and contraceptive drugs and devices (both on a first-dollar basis, with no participant cost-sharing). See the discussion in Section 4.a below of the Supreme Court's decision in the *Hobby Lobby* and *Little Sisters of the Poor* cases, with regard to contraceptive coverage.

The Act effectively limits the profit margin that insurers may charge beyond the actual cost of providing the insurance. Specifically, insurance companies must have a medical loss ratio ("MLR") of at least 85 percent in the large group market (50-plus employees) and 80 percent in the individual and small group market. The MLR is (1) the amount spent on medical care and health care quality improvement, rather than on administrative costs, divided by (2) the total premiums paid. If the MLR is below this threshold, the insurer must provide a rebate to the customer.

d. Subsidies. The ACA federally subsidizes the cost of individual health insurance premiums for people whose annual income falls between 100% and 400% of the federal poverty level. The amount of the subsidy is derived from a formula based on the cost, in the individual's geographic area, of a "silver-level" plan. In general, the amount of the subsidy is designed so that a family would pay no more than a certain proportion (9.68%, for 2019) of its income in premiums for a silver plan.

These subsidies are generally automatically calculated when people apply for exchange coverage on-line. If eligible, the participant receives the subsidy in the form of a tax credit which is directly applied against the premium cost (bringing the individual's net expenditure, if his or her income is low enough, to as little as zero).

The American Rescue Plan Act of 2021 improves access to and affordability of health coverage through the Marketplace by increasing eligibility for financial assistance to help pay for Marketplace coverage. The new law will lower premiums for most people who currently have a Marketplace health plan and expand access to financial assistance for more consumers. See Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities, March 2021, https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html.

The ACA also called for a separate, indirect, form of subsidy in the form of "cost-sharing reduction," ("CSR") which effectively lowers the impact, among silver plan purchasers, of coinsurance, deductible and co-pay requirements. The cost of the CSR was originally borne by the federal government, but on October 12, 2017, President Trump signed an executive order in 2017 terminating that practice, an action that had the effect of passing CSR costs on to insurers and thereby effectively increasing policy premiums. Several courts subsequently held that the insurers were entitled to be reimbursed. See, e.g., Court Says Marketplace Insurers Are Entitled to Payments for Reducing Cost-Sharing, but Must Offset Premium Tax Credit Increases, August 18, 2020, Timothy S. Jost, https://www.commonwealthfund.org/blog/2020/court-marketplace-insurers-payments-reducing-cost-sharing.

e. Employer requirements. As will be discussed in greater detail in Part 5 below, the ACA contains a number of provisions designed, by a combination of penalties, subsidies and other means, to extend the availability and scope of employer-provided group health insurance plans. These include most prominently the "employer mandate," under which employers above a certain size must provide minimally valuable coverage to full-time employees or face a financial penalty. An array of other reporting, plan-design and tax obligations also apply to employers under the ACA.

f. Medicaid expansion. In terms of overall coverage effect, perhaps the ACA's most significant feature had to do neither with the individual market nor employer plans but instead with an expansion of Medicaid, the state-administered, partly federally funded program first established during the 1960s for low-income individuals and families. The ACA aimed to expand Medicaid eligibility to all those whose incomes were less than 138% of the federal poverty level. Depending on the state, this represented a major expansion: In Texas and Alabama, for example, the threshold above which Medicaid is unavailable in the absence of expansion to non-disabled adults without children is only 13% of the federal poverty level. The Medicaid expansion was intended to function in a way complementary to the subsidies described in paragraph e above: Below 100% of the federal poverty level, individuals would be eligible for Medicaid; above 138%, for subsidies; and between 100% and 138%, for a choice between the two.

The ACA provided for full funding at the federal level of the cost of Medicaid expansion for the first three years of its effectiveness (2014 through 2016); thereafter the federal share of cost transitioned over several years to 90%, with the states shouldering the remaining 10%. As enacted, the ACA provided for penalties to apply to any state that did not elect to expand Medicaid coverage, but this feature of the Act was struck down on constitutional grounds by the Supreme Court in 2012 in the *Sebelius* decision described below.

Such is the political opposition to the ACA that as of August, 2021, twelve states had declined to adopt the expansion, despite its cost's principally being borne by the federal government and typically in the face of lobbying by local hospitals and other medical providers for whom the expansion would effectively mean significant additional revenue. [See Kaiser

Family Foundation, Status of State Medicaid Expansion Decisions: Interactive Map, August 10, 2021, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/] In most of these states an unintended "coverage gap" has resulted, for those whose incomes are above the threshold for Medicaid in their state but below that for subsidies under the ACA. Such individuals remain ineligible for any form of government health insurance assistance, while, paradoxically, individuals who earn more money – at least 100% of the federal poverty level – are eligible for premium subsidies under the ACA.

g. New taxes. The Act also contained a series of revenue-raising provisions intended to cover, at least in part, the cost to the federal government of subsidies and other expenditures under the ACA. The first of these is an additional Medicare tax imposed on the wages or earned income of individual taxpayers. [78 Fed. Reg. 71,468] The additional tax is 0.9 percent of wages (self-employment income) over $200,000 ($250,000 for married taxpayers filing jointly, $125,000 for a married employee filing a separate return), increasing the employee-paid Medicare tax on this income from 1.45 percent to 2.35 percent. An employer must withhold the tax from wages it pays to an employee in excess of $200,000 in a calendar year, regardless of the individual's filing status or wages paid by another employer. The Act also provided for a new net investment income tax, which is 3.8 percent of net investment income for high income individuals, estates, and trusts. [78 Fed. Reg.72394).]

A special revenue-raiser was included in the Act for the "Patient-Centered Outcomes Research Trust Fund," which is intended to "assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine." See https://www.irs.gov/affordable-care-act/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers, last reviewed or updated Feb. 12, 2021. These provisions were intended to support another of the ACA's goals: to find new ways of increasing the efficiency and reducing the overall cost of the American health care system. The DoL has indicated that these fees (unlike the reinsurance contributions) generally are not permissible plan expenses under ERISA, since they are imposed on the plan sponsor and not the plan.

A 40 percent excise tax (the so-called "Cadillac tax") was originally scheduled to take effect in 2018 for extra-valuable employer-provided health insurance, applicable where inflation-adjusted health coverage costs exceeded $10,200 for single coverage and $27,500 for family coverage, subject to certain adjustments [Act § 9001]. The thresholds increased at CPI + 1% in 2018 and 2019, and CPI only thereafter. As a result, more and more plans would be subject to the tax if, as is almost certain in the short term, health care inflation exceeds the general rate of inflation. The tax would be imposed on the insurer, or on the plan sponsor if the plan is self-insured. Liability for the tax was based on the total cost of benefits, not what the employer pays, so shifting costs to employees would not help. The effective date of the tax was delayed for two years, from 2018 to 2020, as part of the Bipartisan Budget Act of 2015, Pub. L. No. 114-74, and the tax was subsequently repealed by H.R. 1865, the Further Consolidated Appropriations Act of 2020.

4. SCALE-BACK

From its inception the ACA has been highly controversial and politically charged. The debate implicates fundamental disagreements over the proper role of government in ensuring the availability of health care, and, more generally, the proper size and scope of the social safety net. Ultimately, most of the major elements of the Act have so far survived, the major exception being the individual mandate, which was legislatively repealed in 2017 (effective beginning in 2019). However, as of the date of this Supplement a major new challenge is pending in the *Kelley v Becerra* case discussed below.

a. Legal challenges. Early legal challenges to the Act took three main forms: a challenge to the constitutionality of the Act's individual mandate; a challenge to the constitutionality of the Act's contraceptive mandate; and a challenge to the availability of premium subsidies in the federally-run exchanges. An additional challenge attacked the constitutionality of the procedures by which the Act was passed.

In June, 2012, a sharply divided United States Supreme Court held, to the surprise of many, that the Act is constitutional. The most controversial provision, the individual mandate, was upheld as a valid exercise of the taxing power, although the Court rejected the Government's argument that the statute was a valid exercise of Congress' commerce power. *National Federation of Independent Business et al v. Sebelius*, 132 S. Ct. 2566 (June 28, 2012). As noted above, however, the Court struck down the application of penalties under the Act to states that opted against Medicaid expansion.

The Religious Freedom Restoration Act of 1993 (RFRA) prohibits the Federal Government from substantially burdening a person's exercise of religion, even if the burden results from a rule of general applicability, unless the Government demonstrates that application of the burden to the person is in furtherance of a compelling governmental interest, and is the least restrictive means of furthering that compelling governmental interest. Regulations promulgated by HHS under the ACA require employer group health plans to furnish "preventive care and screenings" for women without "any cost sharing requirements." Nonexempt employers are generally required to provide coverage for the 20 contraceptive methods approved by the Food and Drug Administration. In *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), the Supreme Court held by a 5–4 majority, and over strong dissents, that, as applied to closely held corporations, the regulations violate RFRA. In July, 2020, by a vote of 7-2, the Supreme Court in *Little Sisters of the Poor v. Pennsylvania*, 140 S. Ct. 2367, rejected a challenge from two states that argued that new rules issued in 2017, that expanded an exemption from the mandate to allow private employers with religious or moral objections to opt out of providing coverage without any notice, violate both the ACA itself and the federal laws governing administrative agencies.

A different legal challenge asserted that premium subsidies—tax credits, described in Section 3.d above, designed to help lower- and moderate-income Americans buy health insurance—were available only to residents of states that had established their own insurance exchanges. If accepted, that argument would have left residents of roughly two-thirds of the

states without subsidies, because instead of establishing exchanges, those states relied on the federal government to operate an exchange for them. In June 2015, the Supreme Court upheld an IRS rule making subsidies available to residents of all states. *King v. Burwell*, 135 S. Ct. 2480 (2015).

Opponents of the Act also challenged the process by which it was adopted. They claimed that it ran afoul of the Constitution's Origination Clause, which requires that bills "for raising revenue" must originate in the House of Representatives. U.S. Const. art. I, § 7. The District of Columbia Circuit rejected the challenge, and the Supreme Court denied review. Some of the circuit judges concluded that the Act was not a bill for raising revenue, while others opined that it was, but that the procedure used—in which the Senate replaced the language of an unrelated House bill with the text that became the ACA—satisfied the Origination Clause. *Sissel v. U.S. Dept. of Health & Human Servs.*, 799 F.3d 1035 (D.C. Cir. 2015) (denying petition for rehearing en banc), *cert. denied*, 136 S. Ct. 925 (2016).

In 2018, a new legal threat arose to the continued viability of the ACA. After Congress in 2017 reduced to zero the penalty for violating the individual mandate (as discussed in subsection b, below), a renewed attack on the constitutionality of the entire statute was launched by the Attorneys General of a number of majority-Republican states. In *Texas v. U.S.*, 340 F. Supp. 3d 579 (N.D. Tex., 2018), these plaintiffs argued that the reduction to zero of the penalty had deprived the individual mandate – which remained in the statute, but now without practical effect – of the taxing-power constitutional justification that had been necessary to its survival in *Sebelius.* Furthermore, the plaintiffs' argument went, the individual mandate was not "severable" from the rest of the statute, and so the zero-penalty mandate's unconstitutionality meant the entire ACA must be invalidated.

These arguments have attracted considerable ridicule: They amount to the position that, specifically by rendering it meaningless, Congress had in 2017 made the individual mandate both crucial and fatal to the constitutional validity of all the rest of the statute. Jonathan H. Adler and Abbe R. Gluck, "What the Lawless Obamacare Ruling Means," New York Times (Dec. 15, 2018), available at https://www.nytimes.com/2018/12/15/opinion/obamacare-ruling-unconstitutional-affordable-care-act.html. Nonetheless, in December of 2018 a judge of the U.S. District Court for the Northern District of Texas accepted the plaintiffs' contentions and invalidated the ACA in its entirety. *Texas v. U.S.*, *supra*. The District Court later stayed the effect of the invalidation pending appeal to the Court of Appeals for the Fifth Circuit, which heard oral arguments on July 9, 2019. Meanwhile, the Trump administration withdrew any defense by the Justice Department to the plaintiffs' challenge and informed the Court of Appeals that its position was that the District Court's decision should be upheld. Letter from U.S. Dept. of Justice to U.S. Court of Appeals for the Fifth Circuit Clerk (March 25, 2019), https://affordablecareactlitigation.files.wordpress.com/2019/03/doj-anti-aca-letter-3-25.pdf. See MaryBeth Musumeci, "Explaining Texas v. U.S.," Kaiser Family Foundation, at https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-5th-circuit-appeal-in-the-case-challenging-the-aca/, for a periodically updated account of the progress of this litigation.

In December, 2019, a majority of the 5th Circuit Court of Appeals held that the individual mandate is unconstitutional because it can no longer be read as a tax, and there is no other constitutional provision that justifies this exercise of congressional power. On the severability question, the court remanded to the district court to provide additional analysis of the provisions of the ACA as they currently exist. Texas v United States, 945 F. 3d 355 (5th Cir., 2019). The Supreme Court granted certiorari and heard oral argument on November 10, 2020. "During the briefing and oral argument, 18 Republican attorneys general and governors, two individuals, and the Trump administration argued against the validity of the ACA, which was defended by 21 Democratic attorneys general and the House…. Republican attorneys general in Montana and Ohio were not parties to the case but filed an amicus brief arguing that the mandate is unconstitutional but severable from the rest of the ACA. And a bipartisan group of governors from Maryland, Maine, New Hampshire, New Mexico, Pennsylvania, and Wisconsin filed a separate brief arguing that the ACA should be upheld. All but four states took a formal position in the lawsuit." [Katie Keith, Supreme Court Rejects ACA Challenge; Law Remains Fully Intact, June 17, 2021 https://www.healthaffairs.org/do/10.1377/hblog20210617.665248/full/]

Following the 2020 election, the Biden administration formally changed the Federal government's position in the litigation. The Department of Justice's new position was that the individual mandate remains constitutional. DOJ's argument did not address standing.

The Court held by a 7-2 majority that that none of the plaintiffs had standing to challenge the individual mandate, because they had not shown a past or future injury *fairly traceable* to the defendants' conduct in enforcing the specific provision (the individual mandate) they attacked as unconstitutional. Justice Breyer's opinion was joined by the Chief Justice and Justices Thomas, Sotomayor, Kagan, Kavanaugh and Barrett. Justice Thomas filed a concurring opinion. Justice Alito filed a dissent, in which Justice Gorsuch joined. According to the majority opinion, "We do not reach these questions of the Act's validity, however, for Texas and the other plaintiffs in this suit lack the standing necessary to raise them. We proceed no further than standing."

According to one comment, "The decision itself has no practical impact and has preserved the status quo. The ACA remains fully in effect, and the law will continue to function as it has since the individual mandate penalty was set to $0 beginning in 2019. The Court's decision does not, and of course cannot, address future challenges to the law. But this is the Court's third rejection of a broad, global challenge to the ACA in less than a decade. The decision in California v. Texas—with an even stronger conservative majority on the Court—shows once again that the Court is loath to make broad changes to the ACA. This could be interpreted as a signal that additional changes to the ACA, including those desired by ACA opponents, should come from Congress (not the federal judiciary)." [Keith, above]

The Court's holding on the standing issue is not surprising, given the Justices' comments at oral argument. It is disappointing that the Court did not address any of the other issues argued by the parties, but this is entirely consistent with the Court's general approach- pragmatic if sometimes frustrating- of not deciding issues it does not need to address in order to resolve a particular case.

*Kelley v Becerra***,** originally filed in 2020 as Kelley v Azar, is currently pending in Texas before Judge Reed O'Connor, the same judge who would have struck down the entire ACA. [Case No. 4:20-cv-00283, N. D. Tex] The plaintiffs are religious conservatives, and what Judge O'Connor calls "Free-Market Plaintiffs," who wish to buy health plans that do not cover all of the preventive services that insurers are currently required to cover. Some of the plaintiffs object to a requirement that insurers pay for pre-exposure prophylaxis ("PrEP"), drugs that are very effective in preventing the transmission of HIV, because they believe that PrEP encourages homosexual activity. "The plaintiffs are individuals and small companies wanting to buy insurance that excludes coverage for contraception and pre-exposure [to HIV] prophylaxis, which they object to on religious and moral grounds. That kind of insurance is impossible to find—and they say the Affordable Care Act is to blame." [Nicholas Bagley, The Next Major Challenge to the Affordable Care Act, https://www.theatlantic.com/ideas/archive/2021/06/next-major-challenge-affordable-care-act/619159/]

Section 2713 of the ACA requires insurers to offer coverage *without cost-sharing* for high-value preventive services, screenings, and vaccines. This has become particularly important as health plans with high cost-sharing have proliferated. Section 2713 applies to services, treatments, or vaccines that "have in effect a recommendation from," or are "supported by," one of three different bodies: the Preventive Services Task Force (PSTF), the Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration (HRSA), the only one of the three that is an actual government agency.

"The stakes will be lower this time around—the whole law isn't threatened. But they're significant nonetheless. If the plaintiffs win, insurers could force their customers to pay out of pocket for contraception, breastfeeding equipment and support, and drugs to prevent HIV infection. They could even start charging people for COVID-19 vaccines, including any boosters." [Bagley, above]

In an order filed on February 25, 2021 [https://affordablecareactlitigation.files.wordpress.com/2021/03/kelley-order-on-mo-dism-2-25-21.pdf], Judge O'Connor accepted the plaintiffs' argument that their rights were infringed by the unavailability of health policies that do not cover those treatments at all, and the putatively higher premiums for available policies caused by enforcement of the mandates. "He said the plaintiffs "plausibly allege" that if the mandate were eliminated, insurers would return to the pre-ACA world and "meet demand for policies that do not cover these products." He also accepted in principle that some of the plaintiffs made a sufficient case that they are legally injured by ACA requirements for coverage "they do not want or need — for example, free STD testing". [Despite Supreme Court rescue, Obamacare isn't out of the legal woods yet, Michael Hiltzik, June 21, 2021, Los Angeles Times, https://www.yahoo.com/now/column-despite-supreme-court-rescue-211700650.html?soc_src=social-sh&soc_trk=ma]

Judge O'Connor will not issue a final decision until 2022, and any injunction would almost certainly be stayed to allow appeals. In May, 2021, Judge O'Connor denied most of the federal government's motion to dismiss the case and held that the plaintiffs have standing. Kelley v. Azar. [ACA Litigation Round-Up, Part 2: Which 2019 Payment Rule Changes Were Legal?

Plus, More From Judge O'Connor On The ACA, Katie Keith, April 20, 2021 https://www.healthaffairs.org/do/10.1377/hblog20210420.44231/full/]

The plaintiffs claim that Section 2713 violates the "nondelegation doctrine." Congress can delegate power to government agencies only if it provides adequate instructions for how the power is to be exercised. The doctrine has not been invoked to strike down a federal law since the New Deal. "But conservative justices on the Supreme Court have signaled an interest in reviving it in service of a broader campaign to curb the federal government's regulatory power. At the same time, some language from an earlier opinion involving the contraception mandate suggests that at least some justices think Section 2713 is troublingly vague." [Bagley, above]

Another claim involves the appointments clause of the Constitution (U.S. Const. art. II, § 2), which says that "officers of the United States" must be appointed by the president or a court of law or a head of department. None of the members of the three bodies empowered by the ACA to make recommendations appears to have been appointed in a manner that satisfies the clause. Are they "officers of the United States."? If they are, and if they were not properly appointed. they cannot tell anyone to do anything.

All recommendations issued by PSTF and ACIP since 2010 could be in jeopardy, including the one requiring insurers to cover medications without cost-sharing for people at high risk of HIV.

Disregarding HRSA guidelines would have similarly bad consequences.

Coverage for COVID-19 vaccines would also be threatened. In the 2020 CARES Act, Congress required insurers to cover any pandemic-related preventive services or immunizations recommended by PSTF or ACIP. Because ACIP has recommended the Pfizer, Moderna, and Johnson & Johnson vaccines, private insurers must cover them *without* cost-sharing. If the lawsuit succeeds, private insurers could start billing for vaccinations. "This is a huge deal," said Tim Jost, a retired Washington & Lee University law professor who tracks ACA litigation and has written about the suit and other efforts by conservative groups in Texas to undermine the ACA and other health policies. "It's billions and billions of dollars of services that Americans get every year, not just from ACA health plans but also from employer plans. If this benefit ends, it would mean a lot of people would forgo preventive services and end up with much worse medical problems." [As quoted in Millhiser, There's a new lawsuit attacking Obamacare — and it's a serious threat, April 2, 2021, https://www.msn.com/en-us/news/politics/there-s-a-new-lawsuit-attacking-obamacare-and-it-s-a-serious-threat/ar-BB1feLiU]

b. Legislative challenges. Before the 2016 elections, the Republican-controlled House of Representatives approved, many times, legislation to repeal the ACA. After President Donald Trump took office in January 2017, he and congressional Republicans continued to attempt to reverse significant portions of the ACA. Efforts at total repeal, however, ultimately stalled in the Senate – most dramatically with the failure in the early morning hours of July 28, 2017 of a so-called "skinny" repeal bill (that is, one with little or no indication as to what might replace the ACA), with three Republicans and all forty-eight Democrats and Independents voting against the bill.

In December, however, Republicans were able to include in a larger tax bill, which passed both houses, a repeal of one of the Act's original pillars: the individual mandate. The Tax Cuts and Jobs Act of 2017 provides, effective in 2019, for a repeal of the "individual shared responsibility" requirement described at Section 3.a above. (Technically, for Senate procedural reasons, the penalty was not actually repealed but instead set at $0.)

The individual mandate's removal proved not to be a lethal blow to the long-term success of the ACA. Early on, the individual mandate was regarded by most observers as essential to the Act's success: a critical bulwark against adverse selection and a concomitant ruinous upward spiral in policy premiums. For that reason, in fact, the Supreme Court, in upholding the mandate in Sebelius, was at the time widely construed as having saved the Act itself. Some commentators have more recently suggested, however, that the mandate may no longer serve quite so essential a role – the ACA and the availability and desirability of policies on the exchange has already become somewhat established in the public mind; moreover incentives, including subsidies, for acquiring coverage remain in place; and in any case many healthy younger individuals were declining to purchase coverage even in the face of the mandate, preferring to pay the penalty instead. See Dylan Scott, "A Requiem for the Individual Mandate," Vox (April 13, 2018), available at https://www.vox.com/policy-and-politics/2018/4/13/17226566/obamacare-penalty-2018-individual-mandate-still-in-effect. Still, the Congressional Budget Office projected that removal of the individual mandate will result in an increase of 13 million in the number of uninsured people by 2027. Congressional Budget Office Report, "Repealing the Individual Health Insurance Mandate: An Updated Estimate," Nov. 2017, available at https://www.cbo.gov/system/files?file=115th-congress-2017-2018/reports/53300-individualmandate.pdf.

In the aftermath of the individual mandate's repeal, some states have adopted or begun to consider imposing their own state-level insurance coverage requirements. These laws are modeled on the ACA's original requirement, typically requiring residents either to procure coverage or pay some form of penalty. As of December, 2020, five states – California, Massachusetts, New Jersey, Rhode Island and Vermont – as well as the District of Columbia, have adopted such a state-level requirement, and a number of others are considering doing so.

c. Regulatory challenges under the Trump administration. Soon after his inauguration, President Trump issued an executive order directing federal agencies to retard the ACA's implementation and chances for success, to the extent possible without legislative repeal. For example, the order directed agencies to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any state or a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications." Exec. Order No. 13765, 82 Fed. Reg. 8351 (Jan. 20, 2017). In October, the President announced that the government would stop paying "cost-sharing" subsidies under the ACA to insurers. (See Section 3.d above.)

The Trump Administration also sought to undermine the ACA in another, more indirect, way, in the form of expanded availability of "employer association" plans. The change,

promulgated in final form in June, 2018, [83 FR 28912] involves a revision of the regulatory definitions of "employer" and thus "employee benefit plan" under ERISA, which in turn modifies the effect of ERISA' preemption provision, relieving such plans from state insurance regulation and thereby rendering them much more feasible.

The background of this issue is this: In general, the regulation of insurance is the province of state governments. Each state has established an insurance department or insurance commissioner responsible for regulating and maintaining standards for insurance companies operating within that jurisdiction. Regulatory oversight typically includes requiring that policies offered within a state have been approved by the state department or commissioner, and that insurers maintain minimum financial standards including specified minimum reserve levels in order to pay policyholder claims. States also maintain guaranty pools, funded through contributions levied on insurers, through which some minimum level of benefits is guaranteed to policyholders in the event of the insolvency of a state-regulated insurer.

ERISA Section 514(b)(6)(A), discussed at length in Part D of this Chapter, above, provides for limited preemption of state laws that apply to arrangements which are both (i) an "employee welfare benefit" plan and (ii) a "multiple employer welfare arrangement" that is "fully insured." In the case of such an arrangement, state insurance regulation is preempted by ERISA except for standards requiring the maintenance of specified levels of reserves or contributions. The question has been whether arrangements consisting of groups of small employers, banding together to purchase insurance, can meet these tests.

The DoL had historically interpreted "employee benefit plan" in such a context strictly, to include only "a *cognizable, bona fide group or association of employers*, acting in the interests of its employer members to provide benefits for their employees." DoL Advisory Op. 2005-20A (emph. added). Generally this meant that providing insurance had to be an ancillary result of the organization's existence: the organization had to have some other, prior reason for being, such as promoting the commercial interests of employers engaged in the same business. (Otherwise, the DoL was concerned, the formation of associations of unrelated employers could form a back-door means of setting up what was effectively an insurance provider and avoiding state regulation.) The Trump Administration's new rule drastically relaxes this requirement, making clear that the preemptive effect will apply even if the employer association was formed solely for the purpose of procuring insurance for its members.

At the same time, the insurance purchased by the association, if enough people are covered, escapes the ACA's requirements that individual or small-group policies cover EHBs through a bronze-level or better plan. (Nothing prevents such a plan, for example, from excluding coverage for, say, maternity care.) Yet the participating employers also retain their status, by reason of their own small size, as exempt from the employer mandate. Overall, then, the availability of such arrangements posed another potential challenge to the ACA's ability to overcome the adverse selection problem.

In March 2019, in a case filed by the attorneys of twelve majority-Democratic states, the District Court for the District of Columbia held these new regulations invalid as an unreasonable

interpretation of ERISA. *New York v. U.S. Dept. of Labor*, 363 F. Supp. 3d 109. The case is currently on appeal before the Court of Appeals for the District of Columbia Circuit. Meanwhile, despite the pendency of that case, the Republican-controlled legislature of North Carolina overrode the Democratic governor to pass legislation authorizing the establishment in that state of associations under the just-invalidated regulations. Andrew M. Ballard, North Carolina Bucks Court to Allow Association Health Plans, Bloomberg Law (August 26, 2019).

5. THE ACA'S EFFECTS ON EMPLOYER PLANS

The Act amends part A of Title XXVII of the Public Health Service Act (PHSA), relating to group health plans and health insurance issuers in the group and individual markets. PPACA adds section 715 to ERISA and section 9815 to the Internal Revenue Code, to make these provisions of the PHSA applicable to group health plans, and health insurance issuers providing coverage in connection with group health plans, as if those provisions were included in ERISA and the Code. The PHSA sections incorporated by this reference are sections 2701 through 2728.

a. Employer mandate. Penalties are imposed on large employers (50 or more full-time employees, including full-time equivalent employees) that do not provide health benefits to full-time employees, or provide health benefits that are not affordable, or do not provide minimum value. [Code §§ 4980H, 5000A] In determining the number of employees, the controlled group rules of Code §§ 414(b), (c), (m) and (o) (which generally relate to qualified retirement plans) apply.

Generally, an employee is full-time if he or she works an average of 30 or more hours per week. IRS Notice 2012–58 [2012–2 C.B. 436] provides employers with safe harbor methods for determining whether an employee is a full-time employee. [See also Notice 2011–36, 2011–1 C.B 792, Notice 2011–73, 2011–2 IC.B. 474, and Notice 2012–17, 2012–1 C.B. 430]

In February 2014, IRS issued final regulations providing further guidance. [79 Fed. Reg. 8544] The regulations affect only employers that meet the definition of "applicable large employer." Generally, liability for a penalty under Code § 4980H may arise because, with respect to a full-time employee who has been certified to the employer as having received an applicable premium tax credit or cost-sharing reduction, the employer's coverage is unaffordable within the meaning of Code § 36B (c) (2) (C) (i) or does not provide minimum value within the meaning of Code § 36B (c) (2) (C) (ii).

The rules provide that health benefits are "affordable" if the employee portion of the self-only premium for the employer's lowest cost coverage that provides minimum value does not exceed 9.5 percent of the employee's household income.

Under § 36B (c) (2) (C) (ii), a plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of those costs. Act § 1302 (d) (2) (C) sets forth the rules for calculating the percentage of total allowed costs of benefits provided under a group health plan or health insurance plan.

A large employer that fails to offer health coverage to its full-time employees and their dependents may be subject to a nondeductible penalty if any full-time employee enrolls for

coverage through an exchange and qualifies for the premium tax credit or reduced cost-sharing. The maximum annual penalty is $2,000 multiplied by the number of full-time employees in excess of 30.

The law does not require large or self-funded plans either to cover all ten EHBs, or adhere to cost-sharing rules when covering EHBs. However, for large or self-funded employers, EHBs bear on other reform mandates, such as lifetime limits. For example, if a self-funded plan does cover any EHBs, it may not impose limits on them. The rule issued by DHHS, DoL, and Treasury in February, 2013, affirms that states can choose the exact package of benefits that insurers must provide. [78 Fed. Reg. 12834]

Large employers that offer health coverage to their full-time employees and their dependents will potentially be subject to a second nondeductible penalty if at least one full-time employee enrolls in exchange coverage and qualifies for a premium tax credit or reduced cost-sharing because the employer coverage fails to provide minimum value or the provided coverage is unaffordable. The maximum annual penalty is $3,000 for each full-time employee who enrolls in exchange coverage and qualifies for the premium tax credit or reduced cost-sharing, subject to the maximum penalty that could be imposed if no coverage had been offered. Neither of the penalties applies when a retiree or part-time employee enrolls in exchange coverage and qualifies for the premium tax credit or reduced cost-sharing. For a discussion of these penalties, see Alan Tawshunsky, Limiting the Scope of the Employer Mandate Penalties under Section 4980H(a), 2021 New York University Review of Employee Benefits and Executive Compensation.

Under the Act, individuals eligible for Medicaid are not eligible for premium tax credits or cost sharing subsidies and thus the employer penalties do not apply with respect to such employees. If a state does not adopt expanded Medicaid eligibility, employees with income between 100 percent and 138 percent of the federal poverty level in that state could enroll in an exchange plan and receive a premium tax credit or cost-sharing subsidy, thus potentially subjecting the employer to a penalty. “Employers will also need to track Medicaid eligibility requirements by state, as the standards and qualified income levels could vary by state. Employers should monitor those states in which they have a significant workforce to determine whether they have decided to expand Medicaid eligibility.” [Buck Consultants]

b. Other employer plan requirements:

1. Reporting requirements. Employers that sponsor self-insured health plans must provide certification to DHHS regarding whether their health plans provide minimum essential coverage. [I.R.C. § 6051(a) (14)] The Service has issued interim guidance in Notice 2012–9 [2012–1 C.B. 315], which amends and supersedes the guidance provided in Notice 2011–28. [2011–1 C.B. 656] As Notice 2012–9 points out, “This reporting to employees is for their information only. The reporting is intended to inform them of the cost of their health care coverage, and does not cause excludable employer-provided health care coverage to become taxable.”

In order to assist employees with demonstrating compliance with the (now-repealed) individual mandate, plan sponsors must also provide to employees a uniform summary of benefits and coverage, during the open enrollment period. Participants and beneficiaries who enroll other than through an open enrollment period (e.g., new hires), must receive an SBC on the first day of the next plan year. [See 77 Fed. Reg. 8668 and 8706 (Feb. 14, 2012)]

New employees must, at the time of hire, be provided a written notice by their employer about the availability of coverage through exchanges, and how such exchanges can be accessed at the time of hire. [Act § 1512]

2. Substantive requirements. The Act includes a prohibition against waiting periods in excess of 90 days. Notice 2012–59 [2012–2 C.B. 443 (issued by DoL, DHHS and Treasury)] provides guidance on the prohibition. This tracks the requirement already applicable to employer group health plans under HIPAA (see C.2.3, above). As with individual policies, group health plans cannot impose exclusions on coverage for pre-existing conditions. [See 75 Fed. Reg. 37188]

Under the Act, a plan may no longer put lifetime limits on the amount of "essential health benefits" (EHBs) provided by the plan, a common feature of plan design pre-ACA. Also, a plan generally may not impose an annual limit on the amount of EHBs. [ACA § 2711] The prohibitions do not (1) apply to specific treatment limits, like "number of visits" limits, (2) limit the ability of a plan sponsor to exclude all benefits for a specific disease or condition (though such an exclusion may be limited by other state or federal laws), or (3) restrict the plan sponsor's ability to impose limits on nonessential health benefits. [45 CFR § 147.126]

Plans may not impose an annual deductible of more than $2,000 for an individual and $4,000 for any other coverage tier. In addition, they are prohibited from having out-of-pocket maximums that exceed the limits imposed on high deductible health plans that are compatible with health savings accounts. [ACA § 1302(c)] DoL has informally indicated that the limits apply to all group health plans, including self-insured plans.

Plans are prohibited from discriminating against health care providers acting within the scope of their licenses when providing services covered by the plan.

An additional issue concerns the rebates described above in connection with the medical loss ratio (MLR) rules. (See Section 2.c above.) The particular question left unanswered by the Act itself was how rebates under the MLR requirement were to be allocated among participants in a group health plan. The final rule directs issuers to provide rebates to the group policyholder (usually the employer) through lower premiums or in other ways that are not taxable. The process will vary by plan type. Policyholders must ensure that the rebate is used for the benefit of subscribers. The final rule also requires that issuers provide notice of rebates to enrollees and the group policyholder. All enrollees must be given information about the MLR and its purpose, the MLR standard, the issuer's MLR, and the rebate provided.

Self-insured, stop-loss, dental, and vision plans are all exempt from MLR rule. Employers must establish procedures to handle rebates under the MLR rules. [See the DHHS

final rule, 77 Fed. Reg. 28790, May 16, 2012] Plan sponsors must determine whether rebates are plan assets and ensure that they are used consistently with applicable fiduciary responsibilities. [See DoL Technical Release 2011–04]

The ACA contained provisions designed to encourage employers to adopt "wellness incentives" such as smoking-cessation or exercise regimens, by increasing the permitted premium discounts for participating in such programs from 20 percent to 30 percent; 50 percent for programs to reduce tobacco use. The EEOC, however, has struggled to craft regulations implementing this change in the face of apparently countervailing authority under the Americans with Disability Act (given that individuals with disabilities may be less-well positioned to avail themselves of premium incentives). See discussion of the *AARP* case at Chapter 18.C (Supplement), above.

The Act also introduced new rules specifying how a plan must handle an appeal ("internal review"). If the plan still denies payment after considering the appeal, the law allows the participant to have an independent review organization decide whether to uphold or overturn the plan's decision ("external review"). [Appealing Health Plan Decisions, http://www.healthcare.gov/law/features/rights/appealing-decisions/index.html; see also Interim Final Rule, 75 Fed. Reg. 43330 (2010), as amended by 76 Fed. Reg. 37208 (2011); DoL Technical Releases 2010–02, 2011–01 and 2011–02].

3. Non-discrimination requirement. [Public Health Service Act (PHSA) § 2716; I.R.C. §§ 9815(a), 105(h)] Since 1980, self-insured health plans been subject to Code § 105(h), which prohibits discrimination in eligibility or benefits in favor of "highly compensated individuals." If a self-insured plan fails to meet the nondiscrimination requirements, the highly compensated individuals are taxed on some or all of their benefits. The Affordable Care Act extends these nondiscrimination rules to insured health plans.

Under a discriminatory *self-insured* plan, discrimination results in additional income taxation to the highly compensated individuals. A discriminatory *insured* plan may be subject to suit under ERISA, and the plan sponsor may be liable for a penalty of $100 multiplied by the number of individuals discriminated against and the number of days the plan does not comply. I.R.C. § 4980D(b)(1).

In Notice 2010–63 [2010–2 C.B. 420], the IRS requested public comments on guidance needed regarding § 2716. Treasury, the Service, DoL and the Department of Health and Human Services (DHHS) determined that compliance with § 2716 should not be required until a regulation or other administrative guidance of general applicability has been issued. "In order to provide insured group health plan sponsors time to implement any changes required as a result of the regulations or other guidance, the Departments anticipate that the guidance will not apply until plan years beginning a specified period after issuance. Before the beginning of those plan years, an insured group health plan sponsor will not be required to file IRS Form 8928 with respect to excise taxes resulting from the incorporation of PHS Act § 2716 into § 9815 of the Code." [Notice 2010–63; see also Notice 2011–1, 2011–1 C.B. 259, containing a further request

for comments]. It is not clear when such guidance will be issued, but it does not appear to be a priority.

Although enacted in 1978, § 105(h) has not been enforced consistently. In 1986, Congress enacted the notorious Code § 89, which attempted to apply uniform nondiscrimination rules to health and welfare plans. Because of its complexity, § 89 was repealed before going into effect. Time will tell whether the ACA provision will fare any better.

Many of the same policy issues raised by the tax subsidy for retirement plans are raised by the tax-free treatment of other employee benefits. For example, if the goal is to encourage health benefits for nonhighly compensated employees, making the benefits tax-free, even if they are subject to nondiscrimination tests, may be a costly and ineffective device for achieving the goal. How would you evaluate a proposal to require employers to provide a certain level of health coverage?

Pages 906-907, Section F:

The annual deductible under a high deductible health plan must be at least $1,400 for an individual and $2,800 for a family for 2020 and 2021. The maximum contribution (employer plus employee) to an HSA is $3,550 ($7,100 for a family) for 2020, which increases to $3,600 and $7,200 for 2021. The $1,000 additional contribution for older employees is not indexed.

Page 908: Before Heading G, insert the following:

A similar defined-contribution vehicle is the "health reimbursement account," or HRA, which originally evolved into existence over a number of years by means of informal practice, without any specific imprimatur under the Code or regulations. An HRA, in contrast to an HSA, is entirely employer-owned and employer-funded, and an employee may not take unused funds with her upon termination of employment. HRAs' status as "employer health plans" under the ACA had been subject to some uncertainty, but in the summer of 2019 HHS and the Treasury Department issued regulations that not only reaffirm the continued permissibility of such accounts, but also their use – subject to certain restrictions – to fund payment of health insurance premiums under individual policies purchased by employees through an ACA exchange. [84 FR 28888 (June 20, 2019)]

Page 921: At the end of the second-to-last paragraph on the page, insert:

The Sixth Circuit has since fully incorporated *Tackett* in its decisions on collectively bargained retiree medical benefits. *See Fletcher v. Honeywell Int'l.*, 892 F.3d 217 (6th Cir. 2018).

Page 939: add the following at the end of paragraph 8:

In November, 2020, the Supreme Court heard oral argument in yet another ERISA preemption case, Rutledge v Pharmaceutical Care Management Association. The case presented a challenge

to the validity of state laws that regulate the reimbursements that pharmacies receive when they sell prescription drugs. The Supreme Court rejected the challenge in an 8-0 decision. Rutledge v Pharm. Care Mgmt. Ass'n, 141 S. Ct. 474 (2020).

For a recent case enumerating possible roles that may be undertaken by a medical plan service provider, and the fiduciary characterization of each, see *Negron v. Cigna Health & Life Ins.*, 300 F. Supp. 3d 341 (D. Ct. 2018).

APPENDIX: PENSION PLAN COST OF LIVING INCREASES

	2019	2020	2021
IRA Contribution Limit	$6,000	$6,000	$ 6,000
IRA Catch-up Contribution	$1,000	$1,000	1,000
IRA AGI Deduction Phase Out Starts at			
Joint return	$103,000	104,000	105,000
Single or Head of Household	$64,000	65,000	66,000
SEP Minimum Compensation	600	600	650
SEP Maximum Contribution	$56,000	57,000	58,000
SEP Maximum Compensation	$280,000	275,000	270,000
SIMPLE Maximum Contribution	$13,000	13,500	13,500
SIMPLE Catch-up Contribution	$3,000	3,000	3,000
Qualified Plans and 403(b) Plans			
Maximum Annual Compensation	$280,000	285,000	290,000
Maximum Elective Deferral	$19,000	19,500	19,500
Catch-up Contributions	$6,000	6,500	6,500
DC Maximum Annual Addition	$56,000	57,000	58,000
HCE Threshold	$125,000	130,000	130,000
DB Annual Pension Limit	$225,000	230,000	230,000
Key Employee Threshold	$180,000	185,000	185,000
457 Deferral Maximum	$19,000	19,500	19,500
Social Security taxable wage base	$132,900	137,700	142,800