EMPLOYEE BENEFITS LAW:
POLICY AND PRACTICE (5TH EDITION 2018)
STUDENT SUPPLEMENTAL MATERIALS
(Fall 2023)

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CHAPTER TWO

D. SINGLE EMPLOYER PLANS, MULTIEMPLOYER PLANS, AND MULTIPLE EMPLOYER PLANS

Delete the second full paragraph on p. 36 and insert the following new paragraph:

More than one unrelated employer together may establish and maintain a plan, but the employers do not maintain the plan pursuant to a collective bargaining agreement under the Taft-Hartley Act. In this situation, the resulting plan is called a *multiple employer plan*. If the plan offers pension benefits, it is known as a *multiple employer pension plan* (MEP). A similar arrangement among unrelated employers that offers welfare benefits (e.g., health insurance) is known as a *multiple employer welfare arrangement* (MEWA). Historically, federal law frowned on MEPs and MEWAs and made it difficult for these types of plans to be formed by employers. Today, due to statutory and regulatory changes, these types of plans are increasingly popular among employers due to the cost savings that result from economies of scale.

2. ERISA REPORTING AND DISCLOSURE REQUIREMENTS

In the second sentence at the top of p. 76, change "$25" to "$250" and further change "$15,000" to "$150,000."

CHAPTER THREE

1. DEFINED CONTRIBUTION (INDIVIDUAL ACCOUNT) PLANS AND DEFINED BENEFIT PLANS

Add the following new paragraph after the second full paragraph on p. 127:

For participants burdened with student loan debt, employers have the option to make matching contributions to the 401(k) plan based on the participant's *qualified higher education loan payments*. See Code §§ 221(d)(1) (defining higher education loan); 401(m)(4)(D) & (13) (401(k) plans); 408(p)(2)(F) (SIMPLE 401(k) plans). Qualified higher education loan payments must be for student loan debt incurred by the participant and not for a spouse, child, or other family member. Employers can rely on the participant's self-certification that the participant has made the student loan payments, and the participant may designate the employer's matching contribution as a Roth contribution.*

Add the following new subsection after the carryover paragraph at the top of page 133:

e. Multiple Employer Plans and Pooled Employer Plans

A *multiple employer pension plan* (MEP) consists of unrelated employers who together maintain a pension plan, but the employers do not maintain the plan pursuant to a collective bargaining agreement under the Taft-Hartley Act. A MEP can be formed by separate employers who cannot qualify as a single employer under the Code, but who are closely associated through some degree of common ownership or control. For example, assume a franchisor maintains a significant ownership interest in multiple franchisees that is less than the 80% threshold necessary to be treated as a single employer under the Code. See Code § 414 (rules for controlled groups treated as a single employer). Together, the franchisees could maintain a MEP to offer pension benefits to their employees.

Historically, a MEP also could (in theory) be formed by a group or association having a sufficiently close economic or representational nexus to the employers and employees who participated in the plan. This "commonality of interest" requirement, however, was difficult for unrelated separate employers to satisfy. Congress solved this problem by authorizing the *pooled employer plan* (PEP). See ERISA § 3(43). Unlike a MEP, a PEP allows unrelated separate employers to join a defined contribution plan sponsored by an entity called a *pooled plan provider*. A

* Qualified higher education loan payments that can be used for employer matching contributions cannot exceed an amount equal to the annual maximum elective salary deferral limit for the plan (set at $22,500 for 401(k)s and $15,500 for SIMPLE 401(k) plan in 2023), *minus* the elective salary deferral amounts made by the participant to the plan. For example, if the participant in 2023 made $10,000 in elective salary deferrals to the 401(k) plan, the participant could claim an up to $12,500 in qualified higher education loan payments for purposes of employer matching contributions. For administrative convenience, the employer's matching contribution for qualified higher education loan payments may be made less frequently than regular employer matching contributions but must be made at least annually. Note that the eligibility, match rate, and vesting requirements applicable to the employer's matching contribution for the loan payments must be the same as for regular employer matching contributions. These requirements are discussed later in Chapter Three.—Ed..

pooled plan provider, who typically serves as the plan's third-party administrator, is subject to oversight by the Department of Labor. See ERISA § 3(44); DOL Reg. § 2510.3–44.

PEPs are designed to incentivize employers to offer their employees retirement plan benefits by using economies of scale to reduce the costs of plan sponsorship. PEPs also allow the employer to avoid some of the fiduciary responsibilities associated with plan sponsorship. See ERISA § 3(43)(B).

2. AGE AND SERVICE RULES FOR ELIGIBILITY

Add the following after the last paragraph of the second bullet point on p. 139:

- **Can an employee who fails to obtain 1,000 hours of service during a twelve consecutive month period ever become eligible to participate in the employer's plan?**

Yes, under certain circumstances. A special eligibility rule applies to *long-term part-time employees* whose employer sponsors a 401(k) or a 403(b) plan. An employee who works at least 500 hours during two* consecutive 12-month periods is eligible to make elective salary deferrals to the employer's plan. However, long-term part-time employees are not eligible for employer matching or other employer contributions to the plan. Operationally, plan entry dates are the same as for employees who obtain 1,000 hours of service for purposes of eligibility to participate in the plan.

1. THE NONDISCRIMINATION REQUIREMENTS

d. Code Sections 401(k) and 401(m) Tests

Add the following sentence at the end of the first full paragraph on p. 187:

In performing ADP and ACP testing, long-term part-time employees who are eligible to make elective salary deferral contributions to the 401(k) plan, but who are not eligible for employer matching or other contributions, are excluded from testing.

Delete Notes 1, 2, and 3 on pp. 191-193 with the following new Notes 1 and 2. Renumber the remaining Notes accordingly.

* For plan years in 2024, the requirement is at least 500 hours of service during three consecutive 12-month periods, decreasing to two for plan years beginning on or after January 1, 2025.

1. *Automatic Enrollment Features in 401(k) Plans.* Historically, an eligible employee had to complete certain administrative paperwork to participate in a 401(k) plan. This administrative paperwork indicated the employee's choices regarding the amount of the salary deferral contribution and how the employee's 401(k) plan account was to be invested. By requiring each employee to complete this paperwork before participating in the 401(k) plan, however, inevitably some eligible employees failed to act and did not participate in the plan (thereby missing out on employer matching contributions).

To boost contribution rates, employers could adopt an automatic enrollment feature for their 401(k) plans. See ERISA § 514(e) (preempting all state laws regarding automatic contribution arrangements). In a 401(k) plan with automatic enrollment, the employer enrolled each eligible employee as a participant in the 401(k) plan and designated the amount of the employee's salary deferral contribution. If the employee did not want to participate in the 401(k) plan, the employee affirmatively had to "opt out" of the 401(k) plan by completing the necessary paperwork. Research studies of 401(k) plans with an automatic contribution feature found that this feature significantly boosted contribution levels among NHCEs. (These research studies are described in Section E of Chapter Five.) Not all employers, however, chose to incorporate an automatic enrollment feature in their 401(k) plans.

Beginning in 2025, most new 401(k) and 403(b) plans must contain an *eligible automatic contributions arrangement* (EACA). See Code 414(w); Treas. Reg. § 1.414(w)-1. An EACA requires the employer's plan to use an automatic salary deferral contribution rate of between 3% and 10% and automatic escalation of the employee's contribution percentage of 1% per year, up to maximum of at least 10% but not more than 15%. Employees may opt out or elect another percentage for their salary deferral contribution. An employee may "unwind" the automatic contribution without a 10% excise tax penalty under Code Section 72(t) and receive the contribution back (along with applicable earnings) by notifying the plan administrator not later than 90 days after the date of the first automatic contribution was made. SIMPLE 401(k) plans for smaller employers, discussed below in Note 2, are not subject to this requirement. See Code § 414(w)(5). In addition, businesses with 10 or fewer employees, businesses in existence for less than three years, church plans, and governmental plans are not required to an EACA feature, In addition, 401(k) plans that were established on or before December 29, 2022, are grandfathered and do not have to adopt an EACA feature.

2. *SIMPLE 401(k) Plans for Small Employers.* SIMPLE 401(k) plans were created by Congress to encourage smaller employers to provide retirement plans for their employees. SIMPLE 401(k) plans are authorized under Code Section

401(k)(11), which incorporates by reference the terms and definitions of Code Section 408(p).

SIMPLE 401(k) plans may be sponsored by employers who do not maintain another qualified plan and who have no more than 100 employees earning compensation of $5,000 or more in the preceding plan year. See Code §§ 401(k)(11)(C)(i), 408(p)(2)(C)(i)(I). Two characteristics of SIMPLE 401(k) plans are designed to make these plans attractive to smaller employers. First, SIMPLE 401(k) plans are less costly to administer because they are exempt from ADP/ACP testing and the requirements for top heavy plans. See Code §§ 401(k)(11)(A), 401(m)(10), 416(4)(G). Second, due to the exemption from ADP testing HCEs of the employer are guaranteed to be able to make salary deferral contributions to a SIMPLE 401(k) plan up to the maximum dollar amount permitted under federal law. These two characteristics represent the perceived advantages of a SIMPLE 401(k) plan as compared with a traditional 401(k) plan that is subject to ADP/ACP testing.

SIMPLE 401(k) plans have two perceived disadvantages when compared with a traditional 401(k) plan. First, the salary deferral contribution limit for a SIMPLE 401(k) plan is less than the limit for a traditional 401(k) plan. For example, in 2023 the maximum salary deferral contribution amount for a SIMPLE 401(k) plan was $15,500, whereas the maximum salary deferral contribution amount for a traditional 401(k) plan was $22,500.

Second, the employer who sponsors a SIMPLE 401(k) plan must make employer contributions to the plan based upon a statutory formula. See Code § 401(k)(11)(B). Under this statutory formula, the employer has two options for making employer contributions. The employer may make a matching contribution for each participant in the plan that is equal to the participant's salary deferral contribution, up to a maximum employer matching contribution of 3% of compensation for each participant in the SIMPLE 401(k) plan. Alternatively, the employer may make a contribution equal to 2% of compensation for each eligible employee whose annual compensation is at least $5,000, regardless of whether the employee makes salary deferral contributions to the SIMPLE 401(k) plan. All employer contributions to a SIMPLE 401(k) plan must be immediately and fully vested. See Code §§ 401(k)(11)(A)(iii), 408(p)(3).

e. Code Section 416: The Top Heavy Rules

Insert the following sentence before the last sentence in the first full paragraph on p. 196:

In performing top heavy testing on a 401(k) plan, long-term part-time employees who are eligible to make elective salary deferral contributions to the 401(k) plan,

but who are not eligible for employer matching or other contributions, are excluded from testing.

3. DISTRIBUTIONS, ROLLOVERS, AND PARTICIPANT LOANS

a. The Vocabulary of Payments from Qualified Plans

On the last line of p. 206, change "62" to "59½".

b. Distributions and Direct Rollovers

Delete the first sentence in the third full paragraph on p. 208 and substitute the following new sentences:

The plan administrator for a qualified plan must provide a notice to participants describing the option to directly roll over any payment that qualified as an eligible rollover distribution and the tax consequences of failing to elect a rollover distribution. Failure to provide this notice subjects the plan administrator to a penalty of $100 for each failure, not to exceed $50,000 per calendar year.

In the third full paragraph on p. 209, change "$5,000" to "$7,000".

Delete the second and third full paragraphs on p. 210 and replace with the following material:

In addition to being included in the participant's gross income, a distribution from a qualified plan that is made prior to the time the participant attains age 59½ is subject to an excise tax penalty equal to 10% of the distribution amount. See Code 72(t). The excise tax does not apply if:

- The distribution is made to a beneficiary or the participant's estate on account of the participant's death;
- The distribution is being made under the plan because the participant has become totally and permanently disabled;
- The participant has separated from service and has attained age 55;
- The distribution is in the form of an annuity for the life expectancy of the participant or the joint life expectancies of the participant and a beneficiary;
- The distribution is made to the alternate payee of a qualified domestic relations order;

- The distribution is made for unforeseeable or immediate financial needs relating to personal or family emergency expense (limited in amount up to $1,000 and only once annually or until the amount is recontributed to the plan, whichever is longer, with the recontribution period not to exceed three years);
- The distribution is made for the birth or adoption of a child (with the ability to recontribute the amount to the plan at any time without being subject to the Code dollar limits on participant contributions); or
- The distribution is made due to domestic abuse experienced by the participant in a defined contribution plan (limited in amount to the lesser of $10,000 (indexed for inflation) or 50% of the participant's vested accrued benefit under the plan, child (with the ability to recontribute the amount to the plan at any time without being subject to the Code dollar limits on participant contributions).
-

See Code § 72(t). Alternate payees and qualified domestic relations orders are discussed in Section G of Chapter Three. Employers are entitled to rely on a self-certification made by the participant that the criteria for an excise-tax free distribution are satisfied in situations of immediate financial need, the birth or adoption of a child, or domestic abuse.

d. Required Minimum Distributions

Replace the discussion of Required Minimum Distributions on pp. 213-14 with the following new material:

d. Required Minimum Distributions

A participant in a defined contribution plan may want to delay receiving a distribution as long as possible to continue to receive tax-deferred investment earnings on the assets held in the participant's plan account. The required minimum distribution rules of Code Section 401(a)(9) (RMD rules) dictate the longest period of time that a participant may delay receiving a distribution from the plan. Due to the wealth-creating effect of compounding tax-deferred investment earnings on assets held in a qualified plan account, the RMD rules limit the accumulation of wealth in qualified plans. Importantly, the RMD rules do not apply to Roth 401(k) plan accounts (or to Roth IRAs). Thus, the funds in a Roth account do not need to be distributed and can continue to earn compounding tax-free investment earnings.

The function of the RMD rules is relatively simple: to force the distribution of a minimum amount once a participant is well into his or her retirement years and

imposed an income tax on the distribution. In operation, the RMD rules are complex, notwithstanding recent regulatory efforts to simplify their application. See generally Treas. Reg. § 1.401(a)(9)–1 to –9.

The RMD rules are built upon two fundamental concepts. The first concept is the date that distributions must commence (known as the *required beginning date*). The second concept is the amount that must be distributed (known as the *required minimum distribution amount*). A participant's required beginning date is April 1 of the calendar year following the calendar year in which the participant attains age 73 (increasing to age 75 in 2033). If a participant who owns less than 5% of the employer is still employed at age 73 by the employer who sponsors the qualified plan, the participant's required beginning date is delayed until the calendar year when the participant retires. If the participant is deceased and has designated a surviving spouse as the account beneficiary, the surviving spouse may delay the commencement of required minimum distributions from the account until April 1 following the calendar year in which the surviving spouse attains age 73.

The annual required minimum distribution amount is determined by dividing the value of the participant's nonforfeitable accrued benefit by the life expectancy of the participant. If the participant has designated a beneficiary, the annual required minimum distribution amount is determined under life expectancy tables promulgated by the Treasury Department. If the beneficiary is a spouse who is more than ten years younger than the participant, then joint life expectancy may be used to calculate the required minimum distribution amount. The advantage of electing to use a joint life expectancy calculation (in lieu of the participant's life expectancy alone) is to reduce the amount that must be distributed each year pursuant to the RMD rules and subjected to income taxation.

A failure by a qualified plan to comply with the RMD rules of Code Section 401(a)(9) results in plan disqualification. In addition, if the plan distributes less than the required minimum distribution amount dictated by the Code's formula, the participant is subject to an excise tax penalty of 25% of the deficiency amount. See generally Code § 4974. If the failure by the participant to take the RMD amount is corrected in a "timely" manner (a two-year correction window), this excise tax penalty is reduced to 10%. See Code § 4974(e).

Special Rules for Non-Spouse Beneficiaries

The applicable RMD rules for a non-spouse beneficiary of a defined contribution plan account are determined by the date of death of the deceased account owner. If the account owner died on or before December 19, 2019, then required minimum distributions from a deceased participant's defined contribution plan account to a non-spouse beneficiary are governed by one of two possible RMD

rules, depending on whether the participant died before or after the required beginning date. If the participant died after the required beginning date, the beneficiary must receive payments at least as rapidly as the participant had been receiving them. If the participant died before the required beginning date, the benefit must be distributed within five years of the participant's date of death, or the plan can allow payments to "stretch" over a period not exceeding the non-spouse beneficiary's life expectancy. (This "stretch" payment rule also applies to distributions to a non-spouse beneficiary of a so-called "inherited" IRA where the IRA account owner died on or before December 19, 2019.)

A different RMD rule applies to a non-spouse beneficiary if the account owner died on or after December 20, 2019. In this situation, the RMD rules require that distributions to a non-spouse beneficiary from a defined contribution plan account (or an inherited IRA) must be completed by the end of the tenth calendar year following the year of death of the account owner. Exceptions exist if the designated beneficiary is a surviving spouse, disabled, chronically ill, not more than ten years younger than the deceased participant or IRA account owner, or a child of the participant or IRA account owner who has yet not reached the age of majority. This 10-year required minimum distribution rule applies regardless of whether the participant or IRA account owner dies before, on, or after, attaining age 73. See Internal Revenue Serv., Retirement Plan and IRA Required Minimum Distributions FAQs (Sept. 23, 2022). Moreover, distributions must occur each year and cannot be delayed until the last year of the 10-year period. See IRS Notice 2022-53 (Oct. 7, 2022). To date, the Internal Revenue Service has announced that RMD excise tax penalties will not be imposed and qualified plans will not be disqualified under Code § 409(a) for a failure to make required minimum distributions to non-spouse beneficiaries until 2024 due to wide-spread confusion as to payments under the 10-year rule and the time needed for qualified plan administrators to modify their systems for the new rules. See IRS Notice 2022-53 (Oct. 7, 2022), IRS Notice 2023-54 (July 14, 2023).

4. MECHANISMS TO AVOID PLAN DISQUALIFICATION

Delete the material on Mechanisms to Avoid Plan Disqualification on pp. 221-23 and insert the following new material:

An employer's qualified retirement plan must satisfy the requirements of Code Section 401(a) in both *form* and *operation*. A plan is qualified in form if the words of the written plan document comply with Code Section 401(a) and related Treasury Department regulations. A plan is qualified in operation if the plan is administered in compliance with Code Section 401(a), Treasury Department regulations, and the terms of the written plan document.

The Internal Revenue Service has long embraced the philosophy that a qualified plan must adhere strictly to the requirements of Code Section 401(a). This regulatory philosophy of strict compliance applies regardless of the size of the plan or the legal sophistication of the employer. A qualified plan sponsored by a small business with five employees is held to the same standards as the qualified plan of a Fortune 100 company with an entire staff devoted to managing the company's employee benefit programs.

If the employer's qualified plan fails to comply with one of the requirements of Code Section 401(a),* the plan is *disqualified*. Disqualification means that the favorable income tax treatment of the plan is forfeited, and the plan becomes subject to the general rules of income taxation. Under these general rules, employer contributions to the plan are deductible only when matched with inclusion in the participants' gross incomes. Participants are subject to income tax on plan benefits immediately once the benefits are vested. Investment income earned by the assets held in the plan's trust is no longer exempt from income taxation. A limited exception exists if the plan is disqualified due to a violation of Code Sections 410(b) or 401(a)(26). In these instances, only the highly compensated employees of the plan are penalized by being subject to the normal rules of income taxation for their plan benefits. See Code § 402(b)(4)(A)–(B).

Given the complexity of the requirements for qualified plans, it is inevitable that errors and mistakes will occur. There are three regulatory mechanisms that assist employers in maintaining the qualified status of their plans under Code Section 401(a). These mechanisms are the *determination letter*, the *preapproved plan* and the *Employee Plans Compliance Resolution System* (EPCRS).

a. Determination Letters and Preapproved Plans

When establishing a qualified retirement plan, the employer who sponsors the plan desires assurance from the Internal Revenue Service that the plan document as written satisfies all of the requirements of Code Section 401(a) for a qualified retirement plan.† Although obtaining a determination letter from the Internal Revenue Service is not required for a retirement plan to be qualified, the best practice is for the employer to obtain one.

The procedure for obtaining a determination letter varies with the form of the qualified plan adopted by the employer. If the employer adopts an individually

* Similar principles apply to employer plans qualified under Code Section 403(b).

† An employer who sponsors a qualified plan under Code Section 403(b) also may obtain a determination letter. See Rev. Proc. 2022-40.

designed plan, the employer must submit the plan document to the Internal Revenue Service using Form 5300 (reproduced in Appendix D). See generally Rev. Proc. 2022-4, §11. Determination letters with respect to individually designed plans are issued only upon initial qualification of the plan, termination of the plan, and in other circumstances as set forth in guidance published in the Internal Revenue Bulletin. See id. Importantly, an individually designed plan cannot be submitted again for a determination letter if the plan is later amended.

Employers who adopt *preapproved plans* do not apply for determination letters. Instead, the employer may rely on the determination letter obtained by the provider of the preapproved plan.* A preapproved plan is just what it sounds like – a plan document that has been approved in advance by the Internal Revenue Service. Preapproved plans come in two formats: a *single plan document* or a *basic plan document* with an *adoption agreement*. Both formats provide the employer with choices regarding plan operational features, such as the definition of plan compensation, eligibility criteria, or the vesting schedule. In a single plan document, the options available for selection by the employer are contained throughout the document. A basic plan document contains the plan's non-elective terms, and the corresponding adoption agreement allows the employer to select among a limited number of options for features where the employer has a choice, such as the vesting schedule for employer contributions to the plan.

Pre-approved plans are further classified as *standardized* or *non-standardized*. A standardized plan only offers safe harbor operational features that automatically satisfy the Code requirements for qualified plans. Assuming the employer does not make any modifications to the standardized plan, the employer can rely on the determination letter issued to the provider as if it were its own determination letter. The provisions of a non-standardized plan do not have to be safe harbor and the employer is permitted to make very minor modifications to the plan.

If a preapproved plan is later amended due to changes in the Code rules for qualified plans, the provider of the preapproved plan will prepare the necessary amendments and submit them to the Internal Revenue Service for approval. This system is designed to encourage employers to adopt preapproved qualified plan documents and reduce the volume of determination letter requests made to the Internal Revenue Service.

b. Employee Plans Compliance Resolution System

* Similar procedures apply for an individual employer who is part of a multiple employer plan. See Rev. Proc. 2023-4, §14.

The Employee Plans Compliance Resolution System (EPCRS) has several programs that allow the employer to correct various types of errors that, if left uncorrected, would result in plan disqualification. The programs available under the EPCRS are the *Self-Correction Program* (self-correction), the *Voluntary Correction Program* (VCP), and the *Audit Closing Agreement Program* (Audit CAP).

Using self-correction, the employer who has established an internal procedure to ensure plan compliance may correct any "eligible inadvertent error" at any time within a reasonable period after the error is identified, unless the Internal Revenue Service has identified the error before self-correction measures have begun (i.e., the error was identified during an audit). An "eligible inadvertent error" is broadly defined to include any error that occurs despite the plan's internal procedure to ensure plan compliance, but does not include errors that are egregious, relate to the misuse of plan assets, or relate to an abusive tax avoidance transaction. See Code § 305(e).

The VCP remains available to correct plan qualification failures that cannot be self-corrected. The primary advantage of using the VCP over the self-correction method is that the Internal Revenue Service approves the correction method. To access the VCP, the employer must submit a letter, along with supporting documentation and a fee, to the Internal Revenue Service describing the plan's qualification failure and proposing a correction method.

Audit CAP is the correction method of last resort for the employer who sponsors the plan. If the error is identified by the Internal Revenue Service while auditing the plan, any error resulting in plan disqualification may only be corrected through the Audit CAP. Under Audit CAP, the employer must correct the failure and pay a penalty amount that is negotiated with the Internal Revenue Service. The Audit CAP process is concluded when the employer and the Internal Revenue Service enter into final settlement of the matter, known as a *closing agreement*. The closing agreement describes the corrective steps taken by the employer, the negotiated penalty amount paid by the employer, and any other future requirements for ongoing plan operation and administration imposed by the Internal Revenue Service.

2. PLAN TERMINATIONS

Insert the following sentences at the end of the carryover paragraph at the top of p. 244:

For a frozen defined benefit plan that is closed to new participants but allows existing participants to continue to accrue benefits, the plan may qualify for relief from the minimum coverage, minimum participation, and nondiscrimination testing

requirements for qualified plans. To qualify for this relief, the plan's benefits must be shown to have been nondiscriminatory during the year in which the plan was closed to new participants and the following two years.

CHAPTER FOUR

C. INSURED AND SELF-INSURED HEALTH CARE PLANS

1. THE SAVINGS AND DEEMER CLAUSES OF ERISA SECTION 514

Insert the following new Note 4 on p. 312:

4. *Insured and Self-Insured Group Health Plan Benefits After Dobbs.* The Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), overturned *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood of Southeastern Pennsylvania. v. Casey*, 505 U.S. 833 (1992), and returned the right to regulate access to abortion to the individual states. At the state level, the laws vary dramatically. Some states prohibit abortion services; others do not. A few states have criminal penalties for abortion providers. All states have general criminal laws against "aiding and abetting" the commission of a crime.

As a result of the Supreme Court's decisions in *Metropolitan Life* and *FMC Corporation*, two general principles govern the impact of the *Dobbs* decision on coverage of abortion services by employer-sponsored group health plans. First, under *Metropolitan Life* insured plans are subject to state insurance laws. Thus, an insured group health plan will be subject to a state insurance law that prohibits health insurance companies operating within the state from covering abortion services. See ERISA §514(b)(2)(A) (insurance savings clause). Second, under *FMC Corporation* a self-insured group health plan is not subject to regulation by state insurance laws because such State laws are preempted. See ERISA § 514(a) (preemption State laws that "relate to" an employee benefit plan), (b)(2)(B) (deemer clause). Thus, an employer self-insured group health plan may continue to offer coverage for abortion services irrespective of state insurance law.

The resolution of other issues raised by *Dobbs* remains. Unclear. For example, ERISA Section 514(d) specifically excludes from ERISA preemption "any generally applicable criminal law of a State." Thus, state criminal laws for aiding and abetting a crime *could* (in theory) be applied to a plan sponsor or plan administrator for a group health plan, even a self-insured plan, that provided coverage of abortion services in *another* state, or that permitted provided a travel reimbursement benefit for women who obtained an abortion in another state. (To

date, no plan sponsor or plan administrator has been prosecuted under these theories.) Adding to the uncertainty, if an employer uses a self-insured group health plan to provide a travel reimbursement benefit for abortion services provided in another state, the travel reimbursement benefit would violate the federal Mental Health Parity and Addiction Equity Act (MHPAEA) unless the plan offered the same travel reimbursement benefit for mental health conditions. (The MHPAEA is discussed later in Chapter Four.) Although to date no plan sponsor or plan administrator has been sued under the MHPAEA, this uncertainty has led employers to offer travel reimbursement benefits *outside* of their group health plans, making the travel reimbursement amount taxable.

2. HOW SELF-INSURED PLANS WORK

Delete Note 3 on pp. 320-21 and insert the following new Note 3:

3. *Association Health Plans.* An *association health plan* (AHP) is a group health plan that provides coverage to individuals and employers who are members of an employer trade association, chamber of commerce, or similar organization. Unlike a MEWA, an AHP is treated by the Department of Labor as a single-employer plan, rather than as a collection of unrelated single-employer plans.

As with MEPs in the pension plan context, historically the requirements to qualify as an AHP were difficult to satisfy. The federal courts required that the "entity that maintains the plan and the individuals that benefit from the plan [must be] tied by a common economic or representation interest, *unrelated to the provision of benefits*." Wis. Educ. Ass'n Ins. Tr. v. Iowa State Bd. of Pub. Instruction, 804 F.2d 1059, 1063 (8th Cir. 1986) (emphasis added); see MD Physician & Assocs., Inc. v. State Bd. of Ins., 957 F.2d 178, 185–86 (5th Cir. 1992) (same). The Department of Labor's view was that in determining whether an association could qualify as a sponsoring "employer" for the plan under ERISA Section 3(5):

> the touchstone [was] whether the group or association has a sufficiently close economic or representational nexus to the employers and employees that participate in the plan. This "commonality of interest" requirement distinguishe[d] bona fide groups or associations of employers who provide coverage to their employees and the families of their employees from arrangements that more closely resemble[d] State-regulated private insurance offered to the market at large. Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614, 616 (proposed Jan. 5, 2018) (citing DOL Adv. Op. Ltr. 94–07A; DOL Adv. Op. Ltr. 2001–04A).

In 2018, the Department of Labor changed its position by issuing regulations that amended the definition of an "employer" in ERISA Section 3(5) and thereby expanded the circumstances under which associations could offer health care benefits as AHPs. Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614 (proposed Jan. 5, 2018 ("AHP Regulations"). The AHP Regulations:

(1) relax the requirement that associations sponsoring AHPs must exist for a reason other than offering health insurance;
(2) relax the requirement that association members must share a common interest, as long as they operate in a common geographic area;
(3) make clear that associations whose members operate in the same industry can sponsor AHPs, regardless of geographic location; and
(4) clarify that self-employed working owners and their dependents are eligible to participate in AHPs.

Id. at 626. Thus, under the AHP Regulations a local chamber of commerce could qualify to offer AHP coverage to its business members, including self-employed working owners.

In *New York v. United States Department of* Labor, 363 F. Supp. 3d 109 (D.D.C. 2019), 11 states (New York, Massachusetts, California, Delaware, Kentucky, Maryland, New Jersey, Oregon, Pennsylvania, Virginia and Washington) plus the District of Columbia challenged the AHP Regulations as beyond the scope of the Department of Labor's regulatory authority in violation of the Administrative Procedures Act and contrary to the insurance market reforms and consumer protections enacted under by Congress in 2010 under the Patient Protection and Affordable Care Act (ACA). On March 28, 2019, the United States District Court for the District of Columbia held in favor of the plaintiff-states, striking down key parts of the AHP Regulations that allowed self-employed working owners and their dependent and unrelated employers to form an "association" that qualified as an "employer" capable of sponsoring a health care plan under ERISA. The District Court further ruled that the AHP Regulations conflicted with the ACA reforms of the individual and small group insurance markets, thereby putting consumers' health and financial security at risk.

In response, the Departments of Labor and Health and Human Services announced they would not bring enforcement actions against already established AHPs or health insurance companies providing coverage to AHPs for violations of the ACA. The Department of Justice filed an appeal, and on February 8, 2021, a three- judge panel of the United States Court of Appeals for the District of Columbia, in a one-page opinion, ordered that "this case is hereby held in abeyance pending further order of the court." New York v. United States Department of Labor, No.19-5125, 18-cv-01747-JDB, at *1 (D.C. Cir. Feb.8, 2021) (per curiam). No

new developments have occurred as of the date of publication since the case was held in abeyance by the Court of Appeals.

3.d. MHPAEA

Insert the following after the second full paragraph on p. 344:

Today, violations of the MHPAEA are likely to be in the form of *nonquantitative treatment limitations* (NQTLs) on mental health or substance use disorder (MH/SUD) benefits. Examples of prohibited include different standards or treatment coverage, access, and approval procedures regarding:

- The number of permitted treatment visits covered under the plan each year
- The standards for determining whether a treatment is "experimental" and therefore excluded from coverage under the plan
- Dosage limits and drug formularies
- Step therapy protocols
- Provider reimbursement rates
- Provider network adequacy
- Eligibility for residential treatment facilities

See U.S. Dep't of Labor, FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act, Part 39 (Sept. 5, 2019).

The COVID-19 pandemic and the resulting increase in demand for mental health and substance abuse services intensified public, regulatory agency, and ultimately Congressional scrutiny of NQTLs. In 2021, Congress amended the MHPAEA to require group health plans and health insurance issuers to perform and document their comparative analyses of the design and application of NQTLs and to make the analysis results available to federal regulatory agencies upon request. This comparative analysis must include the following information:

> • The specific plan or coverage terms or other relevant terms regarding NQTLs and a description of all MH/SUD benefits and medical or surgical benefits to which each such term applies in each respective benefits classification;
> • The factors used to determine that the NQTLs will apply to MH/SUD benefits and medical or surgical benefits;
> • The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and medical or surgical benefits;
> • The comparative analyses demonstrating that the processes, strategies,

evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical/surgical benefits in the benefits classification; and;

- The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA.

See ERISA § 712(a)(8)(A)(i)-(iv). In its mandatory biennial report on the MHPAEA to Congress in 2022, the Department of Labor reported that from February 10, 2021, to October 31, 2021, the EBSA "issued 156 letters to plans and issuers requesting comparative analyses for 216 unique NQTLs across 86 investigations." United States Dept. of Labor, 2022 MHPAEA Report to Congress, 4. The EBSA determined that none of the comparative analyses initially sent to EBSA contained sufficient information to comply with the comparative analysis requirements of the MHPAEA. EBSA later has issued 80 insufficiency letters for over 170 NQTLs, requesting additional information and identifying specific deficiencies. See id. Education and outreach efforts by the EBSA to raise awareness of prohibited NQTLs are ongoing.

4. AFFORDABLE CARE ACT

Delete pp. 344-381 and insert the following new material.

a. History and Overview of Major Features

Rising public dissatisfaction with the cost and quality of health care made comprehensive national health care reform a central issue in the United States presidential election of 2008. The election of President Barack Obama, combined with the election of Democratic majorities in both the House of Representatives and the Senate, moved health care reform to the top of the national domestic policy agenda.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010), into law. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029, became law. Together, these two pieces of legislation form what is today commonly called the Affordable Care Act (ACA).

The ACA enacted reforms to the Medicare and Medicaid programs, the market for health insurance policies purchased directly by individuals from insurance company issuers, and employer-sponsored group health plans. In studying national health care reform, it is important to distinguish reforms directed at public programs and the individual health insurance market from reforms that are specific to employer-sponsored plans. The former are the subject of a course in health care law and public policy. Nevertheless, an overview of how the major provisions of the

ACA operate to expand the scope of health insurance coverage is fundamental to understanding the law's impact on employer-sponsored group health plans.

National health care reform under the ACA originally was designed as a series of changes to be implemented over several years. Beginning in 2011, the ACA prohibited group health plans from imposing lifetime dollar limits and restricted annual dollar limits on essential health benefits provided by the plan. It also prohibited preexisting condition coverage exclusions for children under age 19 and generally required that adult children must be offered coverage under a parent's plan through age 26.

The second set of reforms involved changes to the Internal Revenue Code to raise additional revenue to pay for the expansion of health insurance coverage. Beginning in 2013, a new tax of 3.8% was imposed on unearned income for individuals and the Medicare tax on earned income was increased by 0.9% for high-income taxpayers. For purposes of this tax (which remains in effect), high-income taxpayers are defined as individuals earning wages of at least $200,000 or married couples filing jointly who earn wages of at least $250,000. These amounts are indexed for inflation in future years.

The third set of reforms required individuals to have health insurance that met a specified federal standard. This standard is called *minimum essential coverage*. See generally Code § 5000A. Individual taxpayers without minimum essential coverage (including the dependents of the taxpayer) became subject to a tax penalty under Code Section 5000A. This penalty was set at the greater of a fixed penalty amount (set at $695 for adults) or a percentage of a formula amount based on the taxpayer's modified adjusted gross income. This tax penalty (known as the *individual mandate*) was upheld by the Supreme Court under the Taxing Clause of the United States Constitution in *NFIB v. Sebelius*, 567 U.S. 519 (2012).

To assist uninsured individuals in obtaining minimum essential coverage, the ACA as originally enacted provided for three assistance mechanisms:

(1) *Expanded coverage through employer-sponsored group health plans.* This requirement (known as the *employer mandate*) imposed penalties on large employers who failed to offer minimum essential coverage to their full-time employees, or who offered coverage to full-time employees that was not *affordable* or that did not provide *minimum value* to the plan's participants.[b] For purposes of the employer mandate, a "large" employer is defined as an employer who has at least 50 full-time and full-time equivalent employees. An "employer" is defined as including a controlled group of employers under Code Sections 414(b), (c), (m) and (*o*). See generally Code § 4980H. A "full-time" employee is one who works on average at least 30 hours of service per week. Hours are counted in the same way as hours of service for purposes of determining eligibility for participation in a qualified retirement plan. To determine its number of full-time equivalent employees, an employer must add together all hours worked by part-time employees (including part-time seasonal workers) and then divide the result by 120. See Code § 4980H(c)(2)(E); Final Rule, Shared Responsibility for Employers

b These italicized terms, which have a unique technical meaning, are explained later in Chapter Four.

Regarding Health Coverage, 78 Fed. Reg. 218, 222–23 (Jan. 2, 2013) (to be codified at 26 C.F.R. pts. 1, 54, 301).

(2) *Expanded coverage through individual policies purchased on an Exchange.* The ACA created a system of online marketplaces (known as the "American Health Benefit Exchanges" or just the "Exchange" for short) so that insurance companies can market and sell individual health insurance policies that satisfy state and federal standards for the coverage of *essential health benefits*.[c] Individual policies sold on an Exchange must cover preexisting health conditions. The premiums for policies sold on an Exchange are priced according to a community rating (rather than according to the individual health status of the person(s) covered by the policy). The ACA allows states to choose between (1) establishing a state-operated Exchange for the purchase of individual policies by their residents or (2) using the federal Exchange created and operated by the Department of Health and Human Services. For individuals and families with incomes between 100% and 400% of the federal poverty level,[e] a premium assistance tax credit is available to reduce the cost of the policy's premium.[f]

(3) *Expanded coverage through state-operated Medicaid programs.* The ACA expanded the scope of the jointly funded, but state-operated, federal Medicaid program by requiring each state to provide Medicaid coverage to all adults[g] under the age of 65 with incomes up to 133% of the federal poverty level.[h] The ACA further required that all of these new Medicaid recipients must have a specified package of benefits. This expansion of Medicaid coverage was a significant change in federal health care policy because prior to the enactment of the ACA an individual could not qualify for Medicaid coverage merely on the basis of income. Rather, eligibility for Medicaid coverage was limited to four categories of low-income persons: (1) the disabled, (2) the blind, (3) the elderly, and (4) families with dependent children. The ACA increased federal Medicaid funding to the states by covering 100% of the additional cost of this expanded Medicaid coverage through 2016, with the additional federal funding for expanded Medicaid coverage gradually decreasing to 90% in subsequent years. If a state failed to provide expanded coverage, the

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c Coverage of "essential health benefits" is more extensive than the requirement of "minimum essential coverage" for purpose of compliance with the employer and individual mandates. The significance of this distinction is explained later in Chapter Four.

e In 2023, 100% of the federal poverty level was set at $14,580 for a single individual and $30,000 for a family of four. At the 400% level, these figures were $58,320 and $120,000, respectively. Amounts for residents of Alaska and Hawai'i are slightly higher.

f The premium assistance tax credit is refundable, meaning that if the amount of the credit is greater than the individual's tax liability, he or she receives the difference as a refund (even if he or she did not owe any income tax). The amount of the tax credit is based on the individual's estimated income for the upcoming year. The credit can be paid in advance if the individual desires to use it immediately to offset the cost of the monthly insurance premiums for a policy purchased on an Exchange. If the individual's actual income during the year is more than the estimated amount, the individual must refund to the Treasury Department any excess tax credit that was used during the year to offset monthly insurance premiums for an Exchange policy. This reconciliation occurs when the taxpayer's annual income tax return is filed at the end of the year.

g Dependent children of low-income families can receive health insurance coverage under the state-operated Children's Health Insurance Program (CHIP), even if a parent earns too much income to qualify for Medicaid coverage.

h The text of the ACA states 133% but provides for a new methodology of calculating income that effectively makes the threshold 138%.

ACA authorized the Secretary of the Department of Health and Human Services to withhold *all* federal Medicaid funds from the state.

Subsequent events delayed the implementation of each of these three assistance mechanisms or otherwise reduced their impact in terms of expanding health insurance coverage. These events began in July of 2013, when the federal government delayed enforcement of the employer mandate—first until January 1, 2015, and later until January 1, 2016—for employers who had between 50 and 99 full-time equivalent employees. The establishment of the Exchange system was made far more difficult when a majority of the states opted not to operate their own Exchanges and chose to rely instead on the federal Exchange operated by the Department of Health and Human Services. When the federal and state Exchanges opened for enrollment on October 1, 2013, the federal Exchange and some state-operated Exchanges suffered well-publicized technical glitches. Some individuals who did successfully navigate the enrollment process were disappointed by the premium prices or the limitations on the network of health care providers available for the less expensive insurance policies.

At the same time, many persons who previously had purchased relatively inexpensive individual health insurance policies with limited coverage of health care services and benefits received cancellation notices from their insurance companies. These cancellation notices were required because their policies did not cover the full range of ten essential health benefits without lifetime or annual dollar limits as required under the ACA. Finally, 26 states successfully challenged the mandatory expansion of Medicaid coverage, which the Supreme Court held to be an unconstitutional expansion of Congress's authority under the Spending Clause in *NFIB v. Sebelius*, 567 U.S. 519 (2012). As a result, eligibility for Medicaid coverage based solely on income was not implemented in all states. This created an unanticipated coverage gap for some low-income adults in those states that did not expand Medicaid coverage.

Health care reform and the future of the ACA once again were central issues in the 2016 presidential election campaign. The election of President Donald J. Trump, along with the election of Republican majorities in both the House of Representatives and the Senate, moved health care reform back again to the top of the domestic policy agenda. Congress passed the Tax Cuts and Jobs Act, Pub. L. No. 115–97, 131 Stat. 2054 (2017), which effectively repealed the individual mandate by reducing the individual mandate tax penalty under Code Section 5000A to zero beginning in 2019. The Tax Cuts and Jobs Act did not, however, repeal the employer mandate tax penalty or the other insurance market reforms enacted by the ACA, which remain in effect today.

The chart below summarizes Congressional Budget Office projections regarding the number of insured and uninsured persons under age 65 in the United States for the period 2022 to 2033.

Projected Health Insurance Coverage for People Younger than Age 65, by Calendar Year, 2022 to 2023
(Millions of People)

	Actual, 2022	2023	2024	2025	2026	2027	Average, 2028 to 2032	2033
Total Population Under Age 65	271	271	271	271	271	271	271	273
Employment-Based Coverage	157	155	155	155	156	157	158	159
Medicaid and CHIP	84	83	74	71	71	71	71	72
Subsidized Marketplace	12	14	16	17	12	11	11	11
Unsubsidized Nongroup	5	4	5	5	7	7	7	7
Other Coverage[a]	12	11	11	11	11	11	11	11
Uninsured	24	23	25	26	27	28	28	28
Multiple Sources of Coverage	22	20	15	14	14	14	14	14
Uninsurance Rate (Percent)								
Including all U.S. residents	8.7	8.3	9.3	9.7	10.1	10.4	10.3	10.1
Excluding noncitizens not lawfully Present	6.8	6.4	7.3	7.7	8.2	8.6	8.4	8.2

a. Includes people with other kinds of insurance, such as coverage through the Basic Health Program, Medicare, student health plans, coverage provided by the Indian Health Service, or coverage from foreign sources.

Source: Congressional Budget Office, Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023 to 2033 (May 24, 2023).

DISCUSSION QUESTIONS

1. The centerpiece of national health care reform under the Affordable Care Act was the individual mandate, which required all individuals and their dependents to have minimum essential coverage or else pay a tax penalty. The Tax Cuts and Jobs Act reduced this tax penalty to zero. In your opinion, which approach represents the better public policy?

2. The Exchange system was designed as a private-public partnership between the federal and state governments and the insurance industry. Is such a partnership too complex to manage and operate efficiently? If the goal is to provide all individuals affordable access to health care services, would a single-payer system operated and funded by the federal government be a better approach?

3. According to the Congressional Budget Office, many of the individual who remain uninsured are ineligible for coverage under the Exchange because they are not citizens or otherwise legal residents of the United States. When enacting health care reforms in the future, should Congress extend the benefits and protections of such reforms to include all persons working and residing in the United States, regardless of their immigration status?

b. Summary of Requirements and Counting Employees Under the ACA

The ACA created numerous federal requirements for employer-sponsored group health plans. These requirements are summarized below and discussed in more detail in the material that follows.

- Coverage of ten essential health benefits with no dollar limits on benefits is required; waiting periods are restricted; dollar limits are imposed on annual out-of-pocket payments by participants. Self-insured plans and insured plans of large employers are exempt from the requirement to cover all ten essential health benefits, but any essential health benefits covered remain subject to these requirements.
- Pre-existing health condition coverage exclusions are prohibited; coverage is required for dependents of the employee and adult children up to age 26.
- Rescission of coverage is generally prohibited.
- Plans are required to provide coverage with no participant-cost sharing for immunizations, preventive care, and emergency services.
- Plans must offer participants a choice of physicians for maternity and pediatric services.
- Plans must allow participants the option of independent external review of denied claims for plan benefits (in lieu of pursing ERISA litigation).

Large Employer Versus Small Employer Insurance Markets

For insured group health plans, the ACA looks to state insurance laws to determine whether an employer qualifies for a group health insurance policy on the large employer or the small employer insurance market. Under federal law, the default definition of a "small" employer is one that has 50 or fewer employees. Each state has the option, however, to elect to define a "small" employer as one having 100 or fewer employees for purposes of its small employer insurance market.

Qualifying for a state's large employer insurance market has several advantages that may reduce the cost of an insured group health plan. First, large employer insured plans are not required to provide coverage of the full range of ten essential health benefits mandated by the ACA. In addition, the ACA requires that group policies sold on the small employer market must: (1) be part of a single risk pool for setting premiums; (2) can only consider age, geographic location, family composition and tobacco use in setting rates; and (3) must conform to the actuarial value categories (e.g., platinum, gold, silver, and bronze) established by the ACA. These additional requirements tend to increase the premiums that participants must pay for coverage under a small employer insured plan.

Counting Employees

Before studying the requirements of the ACA in detail, it is important to understand the concept of an "employee" and how "employees" are counted. Counting the number of "employees" of an employer for purposes of the ACA is not necessarily a simple exercise.

- There is one method of counting employees for purposes of the *state-regulated large employer and small employer insurance markets*.
- Under federal law, there is a second method of counting employees for purposes of the ACA requirement that large employers must offer affordable group health plan coverage to their employees (known as the *employer mandate*).
- Under federal law, there is a third method of counting employees when the Internal Revenue Service assesses an *excise tax penalty* on a large employer who fail to comply with the employer mandate under the ACA.

To understand why counting employees became so complicated, a brief history lesson is necessary. Starting with the passage of the McCarran Ferguson Act of 1945, 15 U.S.C. §§ 1011–15, Congress historically has left the regulation of insurance companies and the benefits provided by group health insurance policies to the individual states. ERISA's preemption provisions reflect this traditional federal deference to state regulation by providing that state laws regulating insurance are saved from federal preemption. See ERISA § 514(b)(2)(A).

As explained in Section C of Chapter Four, self-insured group health plans are not subject to regulation under state insurance laws. See ERISA § 514(b)(2)(B); FMC Corp. v. Holliday, 498 U.S. 52 (1990). Over time, two regulatory mechanisms evolved for group health plans. Fully insured (or just "insured") plans are the product of a group health insurance policy, the terms of which are regulated by state insurance laws. Here, as explained above, each state has the power to define its "small" employer and "large" employer insurance markets. States count whole individuals, whether they are part-time or full-time employees, for insurance markets.

In the context of the employer mandate, federal law (which applies to *both* insured and self-insured group health plans), uses the *full-time equivalent employee method*, which was borrowed from COBRA and modified. Recall that for purposes of COBRA coverage under federal law, the "employer" is defined as including all of the members of a controlled group under Code Sections 414(b), (c), (m), and (*o*) (e.g., at least 80% ownership or common control). COBRA continuation coverage must be offered if the employer has 20 or more "full-time equivalent employees" on a typical business day during the prior calendar year. See ERISA § 601(a)–(b); Rev. Rul. 2003–7, 2003-5 I.R.B. 363. Part-time employees are counted as fractions of full-time employees based on the number of hours normally worked by full-time employees in the business. For example, if a full-time employee normally works 40 hours a week, the two part-time employees who each work 20 hours in a week are counted as one full-time employee under COBRA's fractional counting method. Although this fractional counting method makes sense to ensure compliance with federal laws, it does not make sense for purposes of coverage under a health insurance policy. An employer can have "partial" (i.e., part-time) workers, but a health insurance policy must provide coverage to the whole worker. Thus, the state-regulated large employer and small employer insurance markets for employers who desire an insured group health plan count whole employees (not fractions).

The ACA borrows and modifies the COBRA concept of a full-time equivalent employee for purposes of determining whether an employer is subject to the *employer mandate* to offer health insurance coverage. The employer mandate, which

is discussed in detail later in the reading material, is imposed only on "large" employers by the ACA. In the employer mandate context, the ACA defines a "large" employer as one having 50 or more *full-time and full-time equivalent employees*. The counting method for determining full-time equivalent employees is similar to the COBRA approach, but with a twist. A full-time equivalent employee for purposes of the employer mandate under the ACA is defined as an employee who works *an average of 30 or more hours per week* (instead of 20 hours).

The third method of counting employees applies if a large employer fails to comply with the employer mandate and incurs an *excise tax penalty for noncompliance with the ACA*. Here, the full-time equivalent employee method is not used. Instead, the federal excise tax penalty under Code Section 4980H is calculated by only using *actual full-time employees*. This federal excise tax penalty is explained later the reading material. For now, as you continue reading bear in mind that although "full-time employee" and "full-time equivalent employee" may sound alike, these terms represent distinctly different concepts.

c. Requirements for Employer-Sponsored Group Health Plans

Due in part to the fact that the ACA applies to governmental plans, which are not subject to regulation under Title I of ERISA, many of the federal requirements described below were enacted as amendments to the Public Health Services Act, Pub. L. No. 78–410, 58 Stat. 682 (1944) (codified at 42 U.S.C. § 300gg et seq.) (PHSA), and incorporated by reference into ERISA and the Code. See generally ERISA § 715; Code §§ 4980D, 9815. Citations in the reading material that follows are to the appropriate section of the ACA or the HCRA that created the requirement.

Coverage of Ten Essential Health Benefits

The ACA and its implementing regulations focus on plan coverage of ten *essential health benefits*. The ACA's ten essential health benefits are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization coverage;
- Maternity and newborn care services;
- Mental health and substance abuse disorder services, including behavioral health treatment;
- Prescription drug coverage;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including dental and vision care for children under age 18.

ACA § 1302(b); 78 Fed. Reg. 12,834 (Feb. 25, 2013) (codified at 45 C.F.R. pts. 147, 155, 156). Insured group health plans sold in the small employer market must provide the complete range of ten essential health benefits without any lifetime or

annual limitations. (This requirement also applies to any policies sold to individuals through an Exchange.) Insured group health plans sold on the large employer market and self-insured plans sponsored by employers of any size are *not* required to offer the full range of ten essential health benefits. Of course, many of these exempt plans do offer most, if not all, of the ten essential health benefits voluntarily. Moreover, insured plans may already be required to cover many of the ten essential health benefits under state insurance laws. See, e.g., Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985).

All group health plans are prohibited from imposing a waiting period for the commencement of benefits under the plan that is longer than 90 days. Both insured and self-insured group health plans must set maximum annual out-of-pocket limits for participants. In 2023, these limits could not exceed $9,100 for employee-only coverage and $18,200 for family coverage. (All dollar amounts are indexed for inflation in future years.)

Out-of-pocket expenses that must be counted toward the annual maximum limit include deductibles and co-payments, but exclude premiums, "nonessential" health benefits (i.e., those benefits not on the list of ten essential health benefits), and essential health benefits that are provided by medical professionals who are outside of the plan's network. See ACA § 1302(c)(3). Importantly, emergency care services must be treated as in-network and therefore count toward the annual maximum out-of-pocket limit.

Coverage of Pre-Existing Conditions, Dependents, and Adult Children

All group health plans are prohibited from preexisting condition coverage exclusions. The plan must allow dependents of employees to participate in the plan. (Spouses of employees are not required to be covered by the plan, but many employers choose to offer spousal coverage.) In addition, all group health plans are required to offer coverage to an adult child of an employee until the child turns age 26, regardless of the child's marital status, full-time student status, or financial support by the parent. ACA § 1001 (adding PHSA § 2714); HCRA § 2301. For administrative convenience, some plans allow a child who turns age 26 to remain on the parent's plan until the end of the month, or even until the end of the plan year. If an adult child is enrolled in the plan and loses coverage due to the attainment of age 26, the loss of "dependent" coverage under the employer's plan is treated as a COBRA qualifying event and the adult child is entitled to up to 36 months of COBRA continuation coverage. A plan cannot charge a separate or higher premium for coverage of an adult child than for a minor child of the parent. Conforming amendments to the Code provide that the employer's contribution to the plan is not treated as taxable income to an adult child who is covered under the plan. See IRS Notice 2010–38.

Prohibition on Rescission of Coverage

All group health plans are prohibited from rescinding coverage once an individual is enrolled in the plan unless the individual engaged in fraud or intentional misrepresentation in enrolling in the plan. ACA § 1001 (adding PHSA § 2712); HCRA § 2301. This requirement reinforces the nondiscrimination provisions of ERISA Section 702, which prohibit a group health plan from basing an individual's eligibility to enroll in the plan on a health-related factor. See ERISA

§ 702(a)(1)(A)–(H). Cancellation of coverage due to the participant's failure to make a timely premium payment is not considered to be a prohibited rescission of coverage.

Immunizations, Preventive Care, and Emergency Services

All group health plans are required to provide first-dollar coverage of all immunizations and preventive care services. The plan cannot require participants to share in the cost of these benefits by subjecting immunizations and preventive care services to deductibles or co-payments. ACA § 1001 (adding PHSA § 2713). With regard to emergency services, group health plans cannot require pre-authorization for these services and must treat all emergency services as in-network. ACA § 1001 (making group health plans subject to the requirements of PHSA § 2719A).

Selection of Physicians for Maternal and Pediatric Services

Group health plans with managed care features historically have placed restrictions on access to treatment by requiring that referrals to other doctors must be made by a designated primary care physician. Under the ACA, a group health plan that provides for the designation of a primary care physician must permit a child who is covered under the plan to select an available pediatrician as the child's primary care physician. Female participants in the plan must have direct access to obstetrical or gynecological care without having to obtain a referral or an authorization from a primary care physician. ACA § 1001 (making group health plans subject to the requirements of PHSA § 2719A).

Independent External Review of Denied Claims

ERISA has a unique process for a participant to appeal a claim for plan benefits that is denied by the plan's administrator. This process, which is described in Chapter Six, requires the participant to appeal the denied claim first through the plan's internal administrative review process. See generally ERISA § 503. Once the internal administrative appeal process has been exhausted, the participant may challenge the plan administrator's decision by filing a claim in federal or state court under ERISA Section 502(a)(1)(B).

In response to concerns about the objectivity of the internal administrative review process, several states enacted independent external review procedures for claims that were denied by insured plans or HMOs. In *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), the Supreme Court held that these state-operated independent external review processes were not preempted by ERISA Section 514. (*Moran* is reproduced in Chapter Seven.) In the wake of the Supreme Court's decision in *Moran*, many more states enacted independent external review programs for denied claims. But these state-based procedural alternatives to ERISA litigation did not exist in every state, and they did not apply to self-insured plans by virtue of ERISA's deemer clause, ERISA Section 514(b)(2)(B). See generally FMC Corp. v. Holliday, 498 U.S. 52 (1990).

The ACA gives participants in group health plans the option of independent external review of denied claims to participants in group health plans. See ACA § 1001. A plan participant must choose between independent external review of a denied claim or seeking judicial review under Section 502(a)(1)(B) of ERISA. These options are mutually exclusive. The independent external reviewer's decision is

final. Thus, if the reviewer affirms the plan administrator's denial of the claim, the reviewer's decision cannot be appealed by filing a claim for judicial review under Section 502(a)(1)(B). Likewise, independent external review is not available if the participant's claim for judicial review under Section 502(a)(1)(B) is not successful.

Employer self-insured group health plans can satisfy the independent external review requirement by contracting with at least three accredited private independent review organizations (IROs) and rotating assignments among them. See Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals of External Review Processes, 76 Fed. Reg. 37,208, 37,211 (June 24, 2011) (codified at C.F.R. 29 pt. 2590); DOL Technical Bulletin 2010–01, as modified by Technical Release 2011–02. Each state determines the scope of denied claims that are eligible for independent external review under its state-operated process. The scope of denied claims by participants in self-insured plans that are eligible for independent external review by IROs is determined by Department of Labor regulations. See 76 Fed. Reg. at 37,211, 37,216. In general, any claim that involves the exercise of medical judgment is subject to independent external review. See 76 Fed. Reg. at 37,216 (providing examples).

Prior to the enactment of the ACA, the Uniform Health Carrier External Review Model Act (Model Act) was created by the National Association of Insurance Commissioners to encourage states to enact independent external review programs for insured plans and HMOs, and to create consumer protection standards for such programs. Some states followed the terms of the Model Act closely; others did not. The ACA requires that state-operated independent external review programs include consumer protection standards that are similar to those set forth in the Model Act. See PPACA § 1001 (adding PHSA § 2719). Under these consumer protection standards, the participant must exhaust the plan's internal administrative appeal procedure and receive a final adverse determination of the claim before seeking external review of the plan administrator's decision. Model Act § 7. Next, the participant must file a request for external review with the state insurance commissioner. Model Act § 8. Among the consumer protections provided by the Model Act, the independent external reviewer must be an expert in the treatment of the medical condition that is the subject of the participant's claim. If a physician serves as an external reviewer, the physician must be currently licensed and be certified by a recognized American medical specialty board in the area or areas that are the subject of the denied claim. Model Act § 13. The participant may submit additional written information to the independent reviewer to support the participant's claim that was not initially submitted to the plan's administrator. In rendering an opinion, the independent reviewer is not bound by the prior judgments or opinions of the plan administrator. The decision of the independent external reviewer is binding on the plan administrator and cannot be appealed through litigation. Model Act § 11. Similar consumer protection standards apply to the independent review processes operated by accredited IROs for participants in self-insured plans. In the self-insured plan context, however, the request for independent external review is submitted to the plan administrator, who then assigns the claim to one of the plan's IROs for review.

d. Enforcement of the Requirements for Group Health Plans Under the ACA

The coverage and benefits requirements for group health plans under the ACA are incorporated by reference through ERISA Section 715. See ERISA § 715(a)(1) ("the provisions of part A of title XXVII of the Public Health Services Act (as amended by the Patient Protection and ACA) shall apply to group health plans. . .as if included in this subpart."). These requirements are enforced through a nondeductible excise tax penalty imposed on the employer who sponsors the group health plan. The penalty amount is $100 per day (indexed for inflation), per individual affected, for failure to comply with a requirement. See generally Code §§ 4980D, 9801–02, 9811–12, 9815. For an unintentional failure "due to reasonable cause and not due to willful neglect," the maximum excise tax amount that can be assessed in a taxable year for a single employer plan cannot exceed the lesser of: (1) 10% of the employer's group health plan expenses in the prior year or (2) $500,000. See Code § 4980D(b)(3). This limitation does *not* apply if the employer *knowingly* refuses to comply with a requirement without "reasonable cause." Thus, the maximum penalty amount of $100 per day, per affected individual, can be imposed for an employer who willingly refuses to comply with one of the ACA's coverage and benefits requirements. See, e.g., Burwell v. Hobby Lobby Stores, Inc., 573 U.S. 682 (2014).

Group health plan participants or beneficiaries may bring a private civil action under ERISA Section 502(a)(3) against a group health plan, the named plan fiduciary, and the plan's administrator to enforce the ACA requirements for group health plan coverage and benefits. Claims under ERISA Section 502(a)(3) and available remedies are discussed in Chapter Six.

Additional protection is available under federal law for a full-time employee who purchases an Exchange policy using a premium assistance tax credit. Employer retaliation against such an employee is foreseeable because the employee's purchase of an Exchange policy could subject the employer to a nondeductible excise tax penalty under Code Section 4980H. Under Section 18C of the Fair Labor Standards Act (FLSA), an employee who has suffered retaliation can file a whistleblower claim. See ACA § 1558 (adding § 18C to the FLSA); Final Interim Regulations, Procedures for the Handling of Retaliation Complaints Under Section 1558 of the ACA, 78 Fed. Reg. 13,222 (Feb. 27, 2013) (codified at 29 C.F.R. pt. 1984).

e. The Employer Mandate

The ACA originally required that, unless an exemption applied all individuals must maintain minimum essential coverage through a federal or state program, an employer-sponsored group health plan, or an individual health insurance policy for themselves and their dependents. Individuals who failed to maintain minimum essential coverage for themselves and their dependents were required to pay a tax penalty, known as the individual mandate. See generally Code § 5000A. This tax penalty, set at $695 per adult in 2018, was reduced to $0 beginning in 2019 by the Tax Cuts and Jobs Act, Pub. L. No. 115–97, 131 Stat. 2054 (2017). The Tax Cuts and Jobs Act did not, however, repeal the employer mandate tax penalty under Code Section 4980H or the other insurance market reforms enacted by the ACA.

The employer mandate applies only to "large" employers. See Code § 4980H. For purposes of triggering the employer mandate, the ACA defines a "large" employer as one who employs on average *at least 50 or more full-time and full-time equivalent employees*. To determine large employer status for purposes of the employer mandate, the employer looks backward to the prior calendar year when counting employees and hours of service. A *full-time employee* is defined as one who is regularly scheduled to work 30 or more hours of service per week. To determine whether the employee mandate applies, the employer must:

(1) Count the number of actual full-time employees.

(2) Add the number of hours worked by its part-time employees for each month and divide this monthly total by 120 to determine the number of "equivalent" full-time employees for that month.

(3) Add the number of actual and equivalent full-time employees.

(4) Add the month-by-month count of "actual plus equivalent" full-time employees and divide by 12 to determine whether the employer employed an average of 50 or more full-time and full-time equivalent employees during the prior calendar year.

In performing this calculation, adjustments are made for new employers and employers who employ seasonal workers. If an employer is in business for only part of a calendar year, then the calculation is prorated so that only the operational months are used to determine large employer status. See Code § 4980H(c)(2)(E). A statutory exemption applies for employers who have seasonal workers. See Code § 4980H(c)(2)(B).

The ACA's counting method generally applies the same rules as for qualified retirement plans. Hours of service are measured in the same manner as the minimum participation rules for qualified retirement plans. Employees of employers who are part of a controlled group under Code Sections 414(b), (c), (m), or (*o*) are aggregated to determine large employer status. In addition, leased employees under Code Section 414(n) are counted as employees of the employer.

Employers who employ on average fewer than 50 full-time and full-time equivalent employees are classified as "small" employers. Small employers are not subject to the employer mandate and do not have to offer minimum essential coverage through a group health plan to their employees. If a small employer chooses to offer health insurance to its employees, the employer's plan may be a single-employer insured plan purchased on the small employer market, a self-insured plan, or an association health plan.

The employer mandate is set forth in Code Section 4980H. Section 4980H has two components, each with a different employer penalty for noncompliance. The first component, known as the *play or pay penalty*, is found in Section 4980H(a). The second component, known as the *free rider penalty*, is found in Section 4980H(b). Each component has its own unique design features, but certain common concepts are fundamental to the operation of each penalty.

Let's begin with the play or pay component of Section 4980H(a), which provides:

(a) Large Employers Not Offering Coverage.

If—

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one-full-time employee of the applicable large employer [qualifies and has] enrolled for such month in a qualified health plan [offered through an Exchange] with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount [defined under Section 4980H(c)(1) as 1/12 of $2,000, or $2,000 on an annual basis] and the number of individuals employed by the employer as full-time employees during such month.

Although the statutory language of the play or pay penalty is straight-forward, there are several important concepts imbedded in this relatively brief provision. First, the employer is required to offer coverage *only* to its *actual full-time employees*, which are defined in Code Section 4980H(c)(4)(A) as those individuals who are regularly scheduled to work at least 30 hours of service per week. Note carefully that the penalty calculation is different from the calculation of large employer status for purposes of triggering the employer mandate, which requires aggregating the hours of service worked by *part-time* employees to arrive at the number of full-time equivalent employees. This distinction also applies for the purpose of assessing the penalty for noncompliance. The play or pay penalty is triggered only if an *actual full-time employee* applies for individual coverage through an Exchange *and* qualifies for a premium assistance tax credit. The play or pay excise tax penalty of $2,000 on an annual basis is assessed based on the *total number of actual full-time employees* employed by the employer, even if only *one* full-time employee applies for and receives coverage through an Exchange policy and qualifies for a premium assistance tax credit.

In assessing the play or pay penalty, the first 30 full-time employees of the employer are *not* counted, and thus are *penalty-free*. See Code § 4980H(c)(1) (defining penalty), (c)(2)(D) (penalty calculation reduced by 30 full-time employees). In other words, so long as the number of actual full-time employees is 30 or fewer, the employer will not be subject to play or pay penalty for failing to offer minimum essential coverage to its employees. As a result, the design of the play or pay penalty provides an incentive for employers to restrict the number of their actual full-time employees and to use more part-time workers to operate their businesses.

A second important concept imbedded in the statutory language of Section 4980H is the distinction between coverage offered to the individual employee (*employee coverage*), coverage offered to the employee's dependents (*dependent coverage*), and coverage offered to an employee's spouse (*spousal coverage*). *Family coverage* applies to the employee, the employee's spouse, and any dependents. Section 4980H(a) requires that the employer must offer coverage only to employees and their dependents. The employer is *not* required to offer spousal coverage

(although many employers do so voluntarily by offering family coverage). The distinction between employee-only coverage and dependent coverage arises again later in the determination of *affordable coverage*, a concept that underlies the free rider penalty component of the employer mandate under Code Section 4980H(b).

The third important concept imbedded in Section 4980H(a) is *minimum essential coverage*, a technical term that only superficially resembles required coverage of the ten essential health benefits. The concept of minimum essential coverage mirrors the requirement of the individual mandate under Code Section 5000A, which is incorporated by reference in both Sections 4980H(a) and 4980H(b). Code Section 5000A(a) provides:

> **(a) Requirement to Maintain Minimum Essential Coverage**
>
> **An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.**

For purposes of both the employer and individual mandates, minimum essential coverage is defined in Code Section 5000A(f)(2) as including coverage under an employer-sponsored plan that offers more than just *excepted benefits* under Sections 2791(c)(1) through (c)(4) of the Public Health Services Act. Excepted benefits include stand-alone vision and dental plans covering adults, workers' compensation coverage, and coverage limited to a specified disease or illness. See generally 45 C.F.R. § 148.220.

To illustrate, a plan that offers *only* dental or vision care for adults as its benefit would not constitute minimum essential coverage because coverage of dental and vision care for adults is an excepted benefit. But if the plan provided only preventive care services and immunizations, such a plan *would* qualify as minimum essential coverage under the Code Sections 4980H and 5000A. Why would an employer choose to offer a group health plan that provides such a minimal benefit? The incentive is obviously cost reduction. Although any essential health benefit that is covered by an employer's minimum essential coverage plan cannot be subject to lifetime or annual dollar limits, if the plan's coverage is restricted to only one or a few such benefits, the premium price for the coverage is greatly reduced.

This example illustrates why the play or pay penalty component of the employer mandate alone is not an effective mechanism for achieving the policy goal of universal health insurance coverage. Code Section 4980H(a) does not address whether the minimum essential coverage offered by the employer to its full-time employees is *affordable*, or whether the plan's covered benefits are *adequate*. The concepts of affordable and adequate coverage are addressed by the free rider penalty under Code Section 4980H(b), which provides:

> **(b) Large Employers Offering Coverage with Employees Who Qualify for Premium Tax Credits Or Cost-Sharing Reductions**
>
> **(I) In general**
>
> **If—**
>
> **(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum**

essential coverage under an eligible employer-sponsored plan (as defined in section 5000A (f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer* * *[qualify and are] enrolled for such month in a qualified health plan [offered through an Exchange] with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to 1/12 of $3,000 [or $3,000 on an annual basis].

Code Section 4980H(b) is known as the free rider penalty because it addresses the policy concern that employers could offer group health coverage to all of their full-time employees (thus satisfying Code Section 4980H(a)), but at a premium price that would be unaffordable for low-income full-time employees. If the premium charged for coverage under the employer's plan is unaffordable, low-income full-time employees would be better off by purchasing individual health insurance policies through the Exchange system using premium assistance tax credits. Code Section 4980H(b) is designed to deter employers from "free riding" on the Exchange system of premium assistance tax credits for individuals who have a household income that is between 100% and 400% of the federal poverty level.

The key to Code Section 4980H(b) is the triggering mechanism for assessment of the penalty, which requires that a full-time employee of the large employer must receive coverage through an individual policy purchased on an Exchange *and* must qualify for a premium assistance tax credit. An employee who is eligible for coverage offered through an employer group health plan that provides minimum essential coverage, but who instead purchases a policy on an Exchange, is *not* eligible for a premium assistance tax credit if:

(1) the employer's plan has an *actuarial minimum value of at least 60%* (as measured by federal regulations); and

(2) the employee's share of the premium for *employee-only coverage* under the employer's plan does not exceed 9.5% of the employee's *household income*.

See Code § 36B(c)(2)(C)(i)–(ii) (defining employer-sponsored minimum coverage that is affordable and provides minimum value). See generally Final Rule, Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (codified at 45 C.F.R. pts. 147, 155, 156) (regulations for actuarial methods used to determine minimum value).

It is the actuarial minimum value requirement that prohibits employers from offering inadequate health insurance coverage. See, e.g., IRS Notice 2014–69 (plans failing to provide coverage for in-patient hospitalization services or physician services do not satisfy the minimum value requirement). The affordability requirement—the employee's share of the premium cannot exceed 9.5% of the employee's household income—is adjusted annually for inflation. In 2023, this percentage was set at 9.12%. Final regulations issued by the Treasury Department

took the controversial position that "affordability" is based on the cost of *employee-only coverage* under the employer's plan. See Treas. Reg. § 1.36B–2(c)(3)(v)(A)(2). This interpretation provides an incentive for employers to reduce the premium for employee-only coverage, but to increase the premiums for required dependent coverage (which must be offered by the employer to children of employees up to age 26) and optional spousal coverage. See 78 Fed. Reg. at 231–32, 241. The ACA does not prohibit employers from charging higher premiums for dependent, spousal, or family coverage. Employers typically use one of three safe harbor methods to estimate whether employee-only coverage is affordable for each full-time employee. Under these safe harbors, employers are allowed to use Form W-2 wages, an employee's rate of pay, or the federal poverty level (instead of annual household income) in making this affordability determination. See Final Rule, Shared Responsibility for Employers Regarding Health Coverage, 79 Fed. Reg. 8543 (Feb. 12, 2014) (codified at 26 CFR § 54.4980H-5).

Assuming the employer successfully avoids the play or pay penalty of Code Section 4980H(a), what is the financial risk associated with the free rider penalty under Code Section 4980H(b) if the employer's plan is unaffordable for some employees, or the plan fails to provide 60% actuarial minimum value? The potential free rider penalty is limited under Code Section 4980H(b) to the maximum possible play or pay penalty (which includes the reduction for the first 30 full-time employees of the employer). See Code § 4980H(b)(2)(D)(i). If the employer does not have more than 30 full-time employees who have a household income that is between 100% and 400% of the federal poverty level (thereby qualifying for a premium assistance tax credit to offset the cost of an Exchange policy), the employer *will not be penalized at all* if the employer's plan is unaffordable or fails to provide minimum value.

A second, albeit indirect, limitation on the free rider penalty is the price charged for Exchange policies in the employer's market. Recall that the free rider penalty is assessed only if a full-time employee *purchases an Exchange policy* and qualifies for a premium assistance tax credit based on household income. Some Exchange markets may offer policies at prices that, even after deducting the premium assistance tax credit, exceed the amount that individuals are willing to pay for health insurance coverage. The elimination of the individual mandate tax penalty further reduces the incentive for healthy persons to purchase an individual insurance policy through an Exchange. A healthy individual is likely to find a less expensive policy by purchasing insurance directly from an insurer because the premiums for the policy will be determined by the individual's personal health status. In contrast, the premiums for an individual policy purchased through an Exchange are set by a community health rating so that premiums are the same for everyone who purchases the same type of policy (e.g., platinum, gold, silver, or bronze).

NOTES AND QUESTIONS

1. *Challenges to the Individual Mandate*. Legal challenges to the validity of major social legislation are inevitable, and the ACA was no exception. Shortly after its enactment, 26 states joined together to challenge the individual mandate under the

ACA. In *NFIB v. Sebelius*, 567 U.S. 519 (2012), Supreme Court rejected the individual mandate under the ACA as a constitutional exercise of Congress's power to regulate under the Commerce Clause, U.S. Const. Art. I, § 8, cl. 3, but upheld the individual mandate based on Congress's power to "lay and collect Taxes," U.S. Const. Art. I, § 8, cl. 1. The Supreme Court cautioned, however, that "Congress's ability to use its taxing power to influence conduct is not without limits," id. at 572, and that "the power to tax is not the power to destroy while this Court sits," id. at 573. Although Congress reduced the individual mandate tax penalty to zero beginning in 2019, a future Congress could reinstate the individual mandate tax penalty. How much *could* a future Congress increase the individual mandate tax penalty amount under Code Section 5000A to incentivize individuals to obtain health insurance?

2. *Challenges to Payment of Premium Assistance Tax Credits in Federal Exchange States*. Three years after *NFIB v. Sebelius* was decided, the Supreme Court rejected another systemic challenge to the ACA. *King v. Burwell,* 576 U.S. 473 (2015), involved a challenge to a regulation promulgated by the Treasury Department interpreting Code Section 36B. As written by Congress, Code Section 36A authorized the payment of premium assistance tax credits to qualifying taxpayers who enroll in an insurance plan through "an Exchange established by the State." At the time the Supreme Court heard *King v. Burwell*, only 16 states had established their own Exchanges, with 34 states opting instead to use the federal Exchange operated by the Department of Health and Human Services.

The question presented in *King v. Burwell* was "whether the Act's interlocking reforms apply equally in each State no matter who establishes the State's Exchange. Specifically, the question presented [was] whether the Act's tax credits are available in States that have a Federal Exchange." Id. at 479. The Supreme Court held that "the context and structure of the Act compel us to depart from what would otherwise be the most natural reading of the pertinent statutory phrase." Id. at 497. Relying on evidence that withholding tax credits from qualifying individuals in federal Exchange states would result in a "death spiral" of rising health insurance rates, the Supreme Court concluded:

> Congress passed the [ACA] to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter. Section 36B can fairly be read consistent with what we see as Congress's plan, and that is the reading we adopt. Id. at 498.

As a matter of statutory interpretation, do you agree? Or should the Supreme Court apply the "plain language" of the statute? When plain language conflict with Congressional intent, how much leeway should the Supreme Court have in interpreting the technical provisions of major social legislation?

3. *Grandfathered Plans*. Several of the requirements of the ACA do not apply to *grandfathered plan*. A grandfathered plan is an insured or self-insured plan in existence on March 23, 2010, that does not make a subsequent disqualifying change to the terms of the plan. Grandfathered plans today are increasingly rare. In 2020, the last year for which statistics are available, only 14% of covered workers were enrolled in grandfathered health plans. Kaiser Fam. Found., Employer Health Benefits 2020 Annual Survey 20 (2020).

To maintain grandfathered plan status, the plan must maintain: (1) the benefits package offered by the plan or the insurance policy that constituted the plan as of March 23, 2010; (2) the costs (other than premiums) borne by the participants in the plan as of March 23, 2010; and (3) the employer contribution to the plan as of March 23, 2010. With limited exceptions, a change in any one of these three areas results in a loss of grandfathered plan status. Significant administrative paperwork is necessary to operate a grandfathered plan because the burden of proof is on the plan administrator or the policy issuer, who must maintain records and documentation proving that the plan has maintained its grandfathered plan status. Moreover, if the is operated as a grandfathered plan but fails to maintain its grandfathered plan status, the plan will be in violation of the ACA and subject to the tax penalties for noncompliance imposed under Code Section 4980D.

DISCUSSION QUESTIONS

1. *Comparing Legislative Approaches to National Health Care Policy*. Congress embraced an incremental legislative approach to health care reform between 1996 and 2008 by enacting a series of targeted requirements for group health plans aimed at resolving discrete issues. The ACA represents a far more ambitious legislative approach that attempts to simultaneously resolve multiple and interrelated issues. Which legislative approach to reform do you prefer?

2. *Elimination of the Individual Coverage Mandate and the Problem of Adverse Selection*. From the day it was enacted, a strong criticism of the ACA was that the tax penalty for individuals who failed to obtain minimum essential coverage was insufficient to prevent *adverse selection*. If individuals who are healthy wait to obtain health insurance coverage until they have a health condition that requires expensive treatment, then the pool of persons covered under the plan will consist of individuals who incur higher than average medical expenses on an actuarial basis. When the conditions for adverse selection exist, it becomes difficult for the plan to estimate its expenses accurately, and the premiums for coverage for all participants in the group health plan increase to reflect the fact that the pool of participants includes a higher than normal number of individuals who need expensive medical treatment. Adverse selection problems persist under the ACA because the law requires all group health plans to enroll individuals in the plan without preexisting condition coverage exclusions. Assuming you are in good health, would you choose to enroll in your employer's group health plan? Why or why not?

3. *International Economic Competition and the Burden on Employers*. Given that large employers today often compete in a global economy, is the economic burden imposed by the employer mandate too great? Are the penalties imposed on large employers who do not offer affordable group health plan coverage to their full-time workers sufficient to deter large employers from terminating their plans altogether? Can universal health insurance coverage be accomplished *without* group health plans sponsored by large employers?

4. *The Exchanges and Price Competition*. One of the criticisms of the ACA is that the law relies on price competition through the Exchange system to make health insurance policies for individuals more affordable. Critics question whether competition among for-profit insurance companies will result in a fair price for the individual health insurance policies sold through an Exchange. Should a public

option—the ability by an individual or an employer to purchase health insurance coverage directly from the federal government—be created to encourage greater price competition?

5. NO SURPRISES ACT

Building upon the consumer-oriented reforms of the Affordable Care Act, in 2021 Congress passed the No Surprises Act (NSA) to protect patients against large, unexpected medical bills from out-of-network providers. See generally Final Rule Under the No Surprises Act, 87 FR 52618 (Aug. 26, 2022) (describing the harms necessitating the NSA). *Surprise medical bills* can arise when a patent inadvertently receives care from an out-of-network hospital, a doctor, or another health care provider that the patient did not choose. Prior to the NSA, many out-of-network doctors and hospitals billed the patient directly, leaving it up to the patient to submit the out-of-network claim to the patient's group health plan and seek reimbursement. To make matters worse, the patient often was subject to so-called "balance billing." Using balance billing, the out-of-network provider billed the patent for the full fee for the services rendered, rather than the discounted fee that typically is negotiated with health care insurers. If the patient's insurer only reimbursed for the lower discounted fee, the patient would be stuck with paying the balance of the bill (which could be a substantial amount).

Although many states restricted or prohibited these billing practices under state insurance laws, these laws did not apply to employer self-insured group health plans. See ERISA §514(b)(2)(B); FMC Corp. v. Holliday, 498 U.S. 52, 62 (1990)(state insurance laws inapplicable to self-insured plans under the deemer clause). In addition, the states were prohibited under federal law from regulating emergency air-ambulance transportation services.

For participants in ERISA-regulated group health plans,* the NSA is codified at ERISA Sections 716 through 725 and implemented by DOL Regulations 2590.716-1 through .725-4. The NSA protects against surprise medical bills in the following three circumstances:

- The patient receives emergency care at an out-of-network facility or from an out-of-network provider.
- The patient requires and receives emergency air-ambulance transportation (ground-ambulance services are excluded).
- The patient receives elective, non-emergency care at an in-network facility, but is inadvertently treated by an out-of-network health care provider (e.g., a member of a surgical team is not an in-network provider).

The NSA protects group health plan participants from surprise medical bills in these circumstances by requiring group health plans to cover the out-of-network claims and apply in-network cost sharing. The NSA also prohibits doctors, hospitals, and other covered providers from billing patients more than the in-network cost sharing amount for surprise medical bills.

To resolve billing disputes between group health plans and out-of-network providers, the NSA establishes a process for determining the payment amount for

* The No Surprises Act also applies to patients who have health insurance coverage through a health plan or health insurance policy that is not regulated by ERSA and to individuals without health insurance coverage.

surprise, out-of-network medical bills, which begins with required negotiations between the patient's group health plan and the out-of-network provider. If negotiations do not resolve the dispute, the NSA requires that the dispute must be resolved through an independent dispute resolution process. See generally Final Rule Under the No Surprises Act, 87 FR 52618 (Aug. 26, 2022) (describing how billing disputes are to be resolved).

The NSA permits patients to waive their rights and be billed more by out-of-network providers under limited circumstances. For a waiver to be valid, the patient must receive information about the estimated cost of care with the waiver, and the waiver must be made in writing prior to obtaining the treatment. Federal regulations provide for a standardized waiver form. See Ctrs. for Medicare & Medicaid Servs. Standard Notice and Consent Documents Under the No Surprises Act (Version 2 for 2022 and beyond) (available online).

A patient's consent to waive the protections of the NSA must be given voluntarily and cannot be coerced, although an out-of-network health care provider can refuse to provide nonemergency care if the patient refuses to sign a waiver. Health care providers are never allowed to ask patients to waive their rights for emergency services or for inadvertent, non-emergency care by an out-of-network provider. The patient's consent to waive the protections of the NSA must be given at least 72 hours in advance or, if the patient schedules a service less than 72 hours in advance, no later than the day the appointment is made. For health care services rendered on the same day such services are scheduled, the waiver must be given at least 3 hours in advance. Health care providers are prohibited from seeking waivers from patients who are impaired or otherwise limited in their ability to make informed decisions. The waiver form must be printed in the 15 most common languages in the geographic region where consent is being sought. If the patient's own language is not among the 15 most common languages, the health care provider must give the patient a qualified interpreter. The patient's signature is required to give consent, and the patient can revoke the waiver at any time prior to when the services are rendered.

CHAPTER FIVE

C. FIDUCIARY AND CO-FIDUCIARY RESPONSIBILITIES

2.c. The Duties of Prudence and Prudent Diversification of Plan Assets

Insert the following after the last full paragraph on p. 477:

Digital Assets as 401(k) Plan Investment Option

In Compliance Assistance Release No. 2022-01 (Mar. 10, 2022), set forth below, the DOL warned plan sponsors and administrators against including cryptocurrencies as investment options for 401(k) plans.

401(k) Plan Investments in "Cryptocurrencies"

In recent months, the Department of Labor has become aware of firms marketing investments in cryptocurrencies to 401(k) plans as potential investment options for plan participants. The Department cautions plan fiduciaries to exercise extreme care before they consider adding a cryptocurrency option to a 401(k) plan's investment menu for plan participants. Although this release specifically references "cryptocurrencies," the same reasoning and principles also apply to a wide range of "digital assets" including those marketed as "tokens," "coins," "crypto assets," and any derivatives thereof.

Under ERISA, fiduciaries must act solely in the financial interests of plan participants and adhere to an exacting standard of professional care. Courts have commonly referred to these prudence and loyalty obligations as the "highest known to the law." Fiduciaries who breach those duties are personally liable for any losses to the plan resulting from that breach. A fiduciary's consideration of whether to include an option for participants to invest in cryptocurrencies is subject to these exacting responsibilities. ***

At this early stage in the history of cryptocurrencies, the Department has serious concerns about the prudence of a fiduciary's decision to expose 401(k) plan participants to direct investments in cryptocurrencies, or other products whose value is tied to cryptocurrencies. These investments present significant risks and challenges to participants' retirement accounts, including significant risks of fraud, theft, and loss, for all the following reasons:

• **Speculative and Volatile Investments:** The Securities and Exchange Commission (SEC) staff has cautioned that investment in a cryptocurrency is highly speculative. At this stage in their development, cryptocurrencies have been subject to extreme price volatility, which may be due to the many uncertainties associated with valuing these assets, speculative conduct, the amount of fictitious trading reported, widely published incidents of theft and fraud, and other factors. Extreme volatility can have a devastating impact on participants, especially those approaching retirement and those with substantial allocations to cryptocurrency.

• **The Challenge for Plan Participants to Make Informed Investment Decisions:** Cryptocurrencies are often promoted as innovative investments that offer investors unique potential for outsized profits. These investments can all too easily attract investments from inexpert plan participants with great expectations of high returns and little appreciation of the risks the investments pose to their retirement investments. Cryptocurrencies are very different from typical retirement plan investments, and it can be extraordinarily difficult, even for expert investors, to evaluate these assets and separate the facts from the hype. Participants are less likely to have sufficient knowledge about these investments, as compared to traditional investments, or to have the technical expertise necessary to make

informed decisions about investing in them. When plan fiduciaries, charged with the duties of prudence and loyalty, choose to include a cryptocurrency option on a 401(k) plan's menu, they effectively tell the plan's participants that knowledgeable investment experts have approved the cryptocurrency option as a prudent option for plan participants. This can easily lead plan participants astray and cause losses.

• **Custodial and Recordkeeping Concerns:** Cryptocurrencies are not held like traditional plan assets in trust or custodial accounts, readily valued and available to pay benefits and plan expenses. Instead, they generally exist as lines of computer code in a digital wallet. With some cryptocurrencies, simply losing or forgetting a password can result in the loss of the asset forever. Other methods of holding cryptocurrencies can be vulnerable to hackers and theft. These are just a few examples of the custodial and recordkeeping issues that may present additional difficulties for fiduciaries of retirement plans.

• **Valuation Concerns:** The Department is concerned about the reliability and accuracy of cryptocurrency valuations. Experts have described the question of how to appropriately value cryptocurrencies as complex and challenging. Experts have fundamental disagreements about important aspects of the cryptocurrency market, noting that none of the proposed models for valuing cryptocurrencies are as sound or academically defensible as traditional discounted cash flow analysis for equities or interest and credit models for debt. Compounding these concerns, cryptocurrency market intermediaries may not adopt consistent accounting treatment and may not be subject to the same reporting and data integrity requirements with respect to pricing as other intermediaries working with more traditional investment products.

• **Evolving Regulatory Environment:** Rules and regulations governing the cryptocurrency markets may be evolving, and some market participants may be operating outside of existing regulatory frameworks or not complying with them. Fiduciaries who are considering whether to include a cryptocurrency investment option will have to include in their analysis how regulatory requirements may apply to issuance, investments, trading, or other activities and how those regulatory requirements might affect investments by participants in 401(k) plans. For example, the sale of some cryptocurrencies could constitute the unlawful sale of securities in unregistered transactions. Plan fiduciaries must take care to avoid participating in unlawful transactions, exposing themselves to liability and plan participants to the risks of inadequate disclosures and the loss of investor protections that are guaranteed under the securities laws. In addition, as the Financial Industry Regulatory Authority (FINRA) has cautioned, Bitcoin and impliedly other cryptocurrencies have "... been used in illegal activity, including drug dealing, money laundering, and other forms of illegal commerce. Abuses could impact consumers and speculators; for instance, law enforcement agencies could shut down or restrict the use of platforms and exchanges, limiting or shutting off

the ability to use or trade bitcoins." See https://www.finra.org/investors/alerts/bitcoin-more-bit-risky. Similarly, the Financial Crimes Enforcement Network (FinCEN) has expressed concern about the use of cryptocurrencies in connection with illicit activity, and recently noted that the majority of ransomware-related payments were made in bitcoin (Financial Trend Analysis (fincen.gov)). The Department of Treasury's Office of Foreign Assets Control has also observed that OFAC sanctions have increasingly targeted individuals and entities using virtual currency in connection with malign activity.

Based on these and other concerns, EBSA expects to conduct an investigative program aimed at plans that offer participant investments in cryptocurrencies and related products, and to take appropriate action to protect the interests of plan participants and beneficiaries with respect to these investments. The plan fiduciaries responsible for overseeing such investment options or allowing such investments through brokerage windows should expect to be questioned about how they can square their actions with their duties of prudence and loyalty in light of the risks described above.

2.d. Fiduciary Responsibilities and Social Investing

Delete subsection 2.d. on p. 478-80 and insert the following:

The term *environmental, social, and governance (ESG) investing* refer to the practice of making investment decisions that are designed to promote social, environmental, or other public policy goals rather than making investment decisions that are based solely on the investment's anticipated rate of financial return. Examples of ESG investments include investing in the development of affordable housing, investing in a construction project that will be built using only higher-wage union labor, investing in the redevelopment of a blighted area, investing only in the stock of companies that conform to certain wage or working conditions standards in conducting the company's domestic or international business operations, or investing only in the stock of companies with environmental or governance policies that affirmatively seek to mitigate the effects of climate change.

When an ERISA plan fiduciary makes an investment decision or selects an investment option for the plan's participants, several ERISA fiduciary responsibilities are implicated. The exclusive benefit rule under ERISA Section 404(a)(1)(A) limits the extent to which the plan fiduciary may consider the "collateral benefits" of the investment or the investment option for society. In addition, the fiduciary duties of prudence and the prudent diversification of plan assets under ERISA Sections 404(a)(1)(B) and 404(a)(1)(C) govern the plan fiduciary's decision. The Department of Labor's position concerning ERISA fiduciary responsibilities and ESG investments has changed over time, as explained in the press release below.

Press Release: Final Rule on Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights

U.S. Department of Labor
Employee Benefits Security Administration
November 22, 2022

Today, the U.S. Department of Labor released a final rule under the Employee Retirement Income Security Act (ERISA) to empower plan fiduciaries to safeguard the savings of America's workers by clarifying that fiduciaries may consider climate change and other environmental, social, and governance (ESG) factors when they make investment decisions and when they exercise shareholder rights, including voting on shareholder resolutions and board nominations.

Background

Over the last approximately 40 years, the Department has periodically considered how ERISA's fiduciary duties of prudence and loyalty apply to plan investments that promote environmental, social, or governance goals.

In its interpretive guidance during this period, the Department has consistently recognized that ERISA does not prohibit fiduciaries from making investment decisions that reflect ESG considerations, depending on the circumstances. The interpretive guidance has also recognized that the exercise of voting rights and other shareholder rights connected to shares of stock are fiduciary acts subject to ERISA's prudence and loyalty requirements.

However, differences in the tone and tenor of guidance across Administrations during these approximately 40 years have contributed to confusion among stakeholders about these investment issues.

The 2020 Rules

On November 13, 2020, the Department published a final rule, "Financial Factors in Selecting Plan Investments,"* which adopted amendments to ERISA's "Investment Duties"† regulation. The amendments generally required plan fiduciaries to select investments and investment courses of action based solely on consideration of "pecuniary factors," which are factors defined in the regulation.

On December 16, 2020, the Department published a related final rule, "Fiduciary Duties Regarding Proxy Voting and Shareholder Rights,"‡ which also adopted amendments to the "Investment Duties" regulation. These amendments addressed plan fiduciaries' ERISA obligations when voting proxies and exercising other shareholder rights in connection with plan investments in shares of stock.

* 85 Fed. Reg. 72846
† Originally published in 1979 and currently codified at 29 CFR 2550.404a-1.
‡ 85 Fed. Reg. 81658.

These two final rules (the 2020 rules)* sought to address uncertainty in these areas and respond to a perception that investment products could be marketed to ERISA fiduciaries based on goals and purported benefits that are unrelated to financial performance. The 2020 rules became effective in January 2021.

Following publication of the 2020 rules, the Department heard from a variety of stakeholders, including asset managers, labor organizations, corporate America, consumer groups, service providers, workers, and investment advisers. These stakeholders questioned whether the 2020 rules properly reflected the scope of fiduciaries' duties under ERISA to act prudently and solely in the interest of plan participants and beneficiaries. They also questioned whether the Department rushed the rulemakings and failed to adequately consider and address evidence submitted by public commenters on how ESG considerations can improve investment value and long-term investment returns for retirement investors.

The Department also heard from stakeholders that the 2020 rules and investor confusion about the rules were having a chilling effect on appropriate integration of ESG factors in investment decisions. Some stakeholders also expressed concern that under a special provision in the 2020 rules, funds would not be treated as qualified default investment alternatives (QDIAs) solely because they expressly considered climate change or other ESG factors, even if the funds were prudent based on consideration of their financial attributes alone.

President Biden's Executive Orders

Executive Order (E.O.) 13990, "Protecting Public Health and the Environment and Restoring Science to Tackle the Climate Crisis," which was signed on January 20, 2021, directed federal agencies to review regulations that:

1. were promulgated, issued, or adopted between January 20, 2017, and January 20, 2021, and
2. are or may be inconsistent with, or present obstacles to, the policies set forth in the order. Those policies included improving public health, protecting our environment, and bolstering resilience to the impacts of climate change.†

Section 2 of E.O. 13990 stated that for any such identified actions, the head of the relevant agency shall, as appropriate and consistent with applicable law, consider suspending, revising, or rescinding the agency action.

E.O. 14030, "Climate-Related Financial Risk," which was signed on May 20, 2021, set forth policies to mitigate climate-related financial risk as well as actions to help safeguard the financial security of America's families, businesses and workers from climate-related financial

* Codified at 29 CFR 2550.404a-1.
† Available at www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-protecting-public-health-and-environmental-and-restoring-science-to-tackle-climate-crisis.

risk that may threaten the life savings and pensions of America's workers and families.* Section 4 of the order directed the Department to consider publishing for notice and comment a proposed rule to suspend, revise, or rescind the 2020 rules.

Department of Labor Review of 2020 Rules and Enforcement Policy

On March 10, 2021, the Department announced it was reviewing the 2020 rules and issued an enforcement policy statement under ERISA.† The statement announced that, until the publication of further guidance, the Department would not enforce the 2020 rules or otherwise pursue enforcement actions against any plan fiduciary based on a failure to comply with those final rules with respect to an investment, including a QDIA, an investment course of action, or an exercise of shareholder rights.

The 2021 Notice of Proposed Rulemaking

On October 14, 2021, the Department published a Notice of Proposed Rulemaking (NPRM) to amend the "Investment Duties" regulation. The intent of the NPRM was to address the Department's concern that the 2020 rules created uncertainty for ERISA fiduciaries around considering climate change and other ESG factors in investment decisions.

Such uncertainty resulted in the undesirable effect of discouraging ERISA fiduciaries from such considerations, even in cases where this consideration served the plan's financial interest. It also deterred fiduciaries from taking steps that other marketplace investors take in enhancing investment value and performance or improving investment portfolio resilience against the potential financial risks and impacts associated with climate change and other ESG factors.

The Department received approximately 900 written comments and over 20,000 petitions during the 60-day comment period.‡ These comments and petitions came from a variety of parties, including plan sponsors and other plan fiduciaries, individual plan participants and beneficiaries, financial services companies, academics, elected government officials, trade and industry associations, and others, both supporting and opposing the NPRM.

Overview of the Final Rule

* Available at www.whitehouse.gov/briefing-room/presidential-actions/2021/05/20/executive-order-on-climate-related-financial-risk.

† 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 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.

‡ Comments to the NPRM are available at www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/1210-AC03.

The final rule clarifies how ERISA's fiduciary duties of prudence and loyalty apply to selecting investments and investment courses of action and exercising shareholder rights such as proxy voting.

The final rule retains the core principle that the duties of prudence and loyalty require ERISA plan fiduciaries to focus on relevant risk-return factors and not subordinate the interests of participants and beneficiaries (such as by sacrificing investment returns or taking on additional investment risk) to objectives unrelated to the provision of benefits under the plan.

The final rule also reiterates a second core principle, which is that when a plan's assets include shares of stock, the fiduciary duty to manage plan assets includes the management of shareholder rights related to those shares, such as the right to vote proxies.

I. Changes to Clarify Permissibility of Consideration of ESG Factors

An important change adopted in the final rule is the addition of regulatory text clarifying that a fiduciary's duty of prudence must be based on factors that the fiduciary reasonably determines are relevant to a risk and return analysis and that such factors may include the economic effects of climate change and other ESG considerations on the particular investment or investment course of action.*

II. Changes to Qualified Default Investment Alternative Provisions

The final rule removes the special rules for QDIAs that applied under the 2020 rules. Under the final rule, standards applied to QDIAs are no different from those applied to other investments. When selecting a QDIA, a plan fiduciary must, among other things, focus on relevant risk and return factors and not subordinate the interests of participants and beneficiaries (such as by sacrificing investment returns or taking on additional investment risk) to objectives unrelated to the provision of benefits under the plan.

The preamble to the final rule reaffirms that, in addition to the requirements under the "Investment Duties" regulation, other standards apply to QDIAs.†

III. Changes to Clarify the Application of the Duty of Loyalty

The Tiebreaker Test

Another important change to the 2020 rules is the final rule's formulation of the "tiebreaker" standard, which permits fiduciaries to consider collateral benefits as tiebreakers in some circumstances.

* See 29 CFR 2550.404a-1(b)(4).
† See 29 CFR 2550.404a-5.

The 2020 rules required that competing investments be economically indistinguishable before fiduciaries could turn to collateral factors to break a tie. It also imposed a special documentation requirement on the use of collateral factors.

The final rule replaces those provisions with a standard that instead requires the fiduciary to prudently conclude that competing investments or investment courses of action equally serve the financial interests of the plan over the appropriate time horizon. In such cases, the fiduciary is not prohibited from selecting the investment or investment course of action based on collateral benefits, meaning benefits other than investment returns.

The final rule also removes the special documentation requirement that commenters noted created unnecessary burdens to apply the tiebreaker provision and erroneously suggested to some fiduciaries that they should be wary of considering ESG factors, even when those factors are financially relevant to the investment decision. However, the final rule maintains the longstanding principle that the fiduciary may not accept reduced returns or greater risks to secure collateral benefits.*

Investment Alternatives in Participant-Directed Individual Account Plans

The final rule adds a new provision clarifying that fiduciaries do not violate their duty of loyalty solely because they take participants' non-financial preferences into account when constructing a menu of prudent investment options for participant-directed individual account plans.

This addition responds to commenters' suggestions that if accommodating participants' preferences will lead to greater participation and higher deferral rates, it could lead to greater retirement security. Thus, considering whether an investment option aligns with participants' preferences can be relevant to furthering the purposes of the plan.†

IV. Provisions on Shareholder Rights including Proxy Voting

Like the 2020 rules, the final rule adopts a principles-based approach to governing the exercise of shareholder rights. The final rule retains the core principle that when a plan's assets include shares of stock, the fiduciary duty to manage plan assets includes the management of shareholder rights related to those shares, such as the right to vote proxies. Like the NPRM, the final rule makes three noteworthy changes to the 2020 rules' provision on exercises of shareholder rights, including proxy voting.

First, the final rule eliminates the statement in paragraph (e)(2)(ii) of the 2020 rules that "the fiduciary duty to manage shareholder rights appurtenant to shares of stock does not require the voting of every proxy or the exercise of every shareholder right." The final rule eliminates

* See 29 CFR 2550.404a-1(c)(2).
† See 29 CFR 2550.404a-1(c)(3).

this provision because it may be misread as suggesting that plan fiduciaries should be indifferent to the exercise of their rights as shareholders, even if the cost is minimal.

Second, the final rule removes the two "safe harbor" examples for proxy voting policies permissible under paragraphs (e)(3)(i)(A) and (B) of the 2020 rules. One of these safe harbors permitted a policy to limit voting resources to types of proposals that the fiduciary has prudently determined are substantially related to the issuer's business activities or are expected to have a material effect on the value of the investment. The other safe harbor permitted a policy of refraining from voting on proposals or types of proposals if the plan's holding in a single issuer relative to the plan's total investment assets was below a quantitative threshold.

Taken together, the Department believes the safe harbors encouraged abstention as the normal course. The Department does not believe the regulation should encourage abstention as the normal course because of the importance of prudent management of shareholder rights in enhancing the value of plan assets or protecting plan assets from risk. For this reason, the Department is of the view that these safe harbors did not adequately protect the interests of plans and their participants and beneficiaries.

Third, the final rule eliminates specific requirements in the 2020 rules on maintaining records on proxy voting activities (paragraph (e)(2)(ii)(E) of the 2020 proxy voting rule) and monitoring obligations when using investment managers or proxy voting firms (paragraph (e)(2)(iii) of the 2020 proxy voting rule). The maintenance of records provision was widely perceived as treating proxy voting and other exercises of shareholder rights differently from other fiduciary activities. In that respect, it risked creating a misperception that proxy voting and other exercises of shareholder rights are disfavored or carry greater fiduciary obligations than other fiduciary activities.

E. EMERGING FIDUCIARY ISSUES IN 401(K) PLANS

Insert the following at the end of p. 550:

HUGHES V. NORTHWESTERN UNIVERSITY

United States Supreme Court, 2022.

142 S. Ct. 737.

Justice SOTOMAYOR delivered the opinion of the Court.

Under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA plan fiduciaries must discharge their duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an

enterprise of a like character and with like aims." § 1104(a)(1)(B). This fiduciary duty of prudence governs the conduct of respondents, who administer several retirement plans on behalf of current and former employees of Northwestern University, including petitioners.

In this case, petitioners claim that respondents violated their duty of prudence by, among other things, offering needlessly expensive investment options and paying excessive recordkeeping fees. The Court of Appeals for the Seventh Circuit held that petitioners' allegations fail as a matter of law, in part based on the court's determination that petitioners' preferred type of low-cost investments were available as plan options. In the court's view, this eliminated any concerns that other plan options were imprudent.

That reasoning was flawed. Such a categorical rule is inconsistent with the context-specific inquiry that ERISA requires and fails to take into account respondents' duty to monitor all plan investments and remove any imprudent ones. See Tibble v. Edison Int'l, 575 U.S. 523, 530, (2015). Accordingly, we vacate the judgment below and remand the case for reconsideration of petitioners' allegations.

I

This case comes to the Court on review of respondents' motion to dismiss the operative amended complaint. Accepting the allegations in that complaint as true, the relevant facts are as follows.

Northwestern University offers two retirement plans to eligible employees: the Northwestern University Retirement Plan (Retirement Plan) and the Northwestern University Voluntary Savings Plan (Savings Plan). Both Plans are defined-contribution plans. In such plans, participating employees maintain individual investment accounts, which are funded by pretax contributions from the employees' salaries and, where applicable, matching contributions from the employer. Each participant chooses how to invest her funds, subject to an important limitation: She may choose only from the menu of options selected by the plan administrators, i.e., respondents. The performance of her chosen investments, as well as the deduction of any associated fees, determines the amount of money the participant will have saved for retirement.

Two types of fees are relevant in this case. First, the investment options typically offered in retirement plans, such as mutual funds and index funds, often charge a fee for investment management services. Such fees compensate a fund for designing and maintaining the fund's investment portfolio. These fees are usually calculated as a percentage of the assets the plan participant chooses to invest in the

fund, which is known as the expense ratio. Expense ratios tend to be higher for funds that are actively managed according to the funds' investment strategies, and lower for funds that passively track the makeup of a standardized index, such as the S&P 500.

In addition to investment management fees, retirement plans also pay fees for recordkeeping services. Recordkeepers help plans track the balances of individual accounts, provide regular account statements, and offer informational and accessibility services to participants. Like investment management fees, recordkeeping fees may be calculated as a percentage of the assets for which the recordkeeper is responsible; alternatively, these fees may be charged at a flat rate per participant account.

Petitioners are three current or former employees of Northwestern University. Each participates in both the Retirement and Savings Plans. In 2016, they sued: Northwestern University; its Retirement Investment Committee, which exercises discretionary authority to control and manage the Plans; and the individual officials who administer the Plans (collectively, respondents). Petitioners allege that respondents violated their statutory duty of prudence in a number of ways, three of which are at issue here. First, respondents allegedly failed to monitor and control the fees they paid for recordkeeping, resulting in unreasonably high costs to plan participants. Second, respondents allegedly offered a number of mutual funds and annuities in the form of "retail" share classes that carried higher fees than those charged by otherwise identical "institutional" share classes of the same investments, which are available to certain large investors. Finally, respondents allegedly offered too many investment options—over 400 in total for much of the relevant period—and thereby caused participant confusion and poor investment decisions.

In 2017, respondents moved to dismiss the amended complaint. The District Court granted the motion and denied leave to amend. The Seventh Circuit affirmed. This Court granted certiorari.

II

In *Tibble*, this Court interpreted ERISA's duty of prudence in light of the common law of trusts and determined that "a fiduciary normally has a continuing duty of some kind to monitor investments and remove imprudent ones." 575 U.S. at 530. Like petitioners, the plaintiffs in *Tibble* alleged that their plan fiduciaries had offered "higher priced retail-class mutual funds as Plan investments when materially identical lower priced institutional-class mutual funds were available." Id. at 525–526. Three of the higher priced investments, however, had been added to

the plan outside of the 6-year statute of limitations. Id. at 526. This Court addressed whether the plaintiffs nevertheless had identified a potential violation with respect to these funds. The Court concluded that they had because "a fiduciary is required to conduct a regular review of its investment." Id. at 528. Thus, "[a] plaintiff may allege that a fiduciary breached the duty of prudence by failing to properly monitor investments and remove imprudent ones." Id. at 530. This Court then remanded the case for the court below to consider whether the plaintiffs had plausibly alleged such a violation. Id. at 531.

Tibble's discussion of the duty to monitor plan investments applies here. Petitioners allege that respondents failed to monitor the Plans' investments in a number of ways, including by retaining recordkeepers that charged excessive fees, offering options likely to confuse investors, and neglecting to provide cheaper and otherwise-identical alternative investments. As a result, respondents allegedly failed to remove imprudent investments from the Plans' offerings. These allegations must be considered in light of the principles set forth in *Tibble* to determine whether petitioners have stated a plausible claim for relief.

In rejecting petitioners' allegations, the Seventh Circuit did not apply *Tibble*'s guidance. Instead, the Seventh Circuit focused on another component of the duty of prudence: a fiduciary's obligation to assemble a diverse menu of options. The court determined that respondents had provided an adequate array of choices, including "the types of funds plaintiffs wanted (low-cost index funds)." In the court's view, these offerings "eliminat[ed] any claim that plan participants were forced to stomach an unappetizing menu."

The Seventh Circuit erred in relying on the participants' ultimate choice over their investments to excuse allegedly imprudent decisions by respondents. In *Tibble*, this Court explained that, even in a defined-contribution plan where participants choose their investments, plan fiduciaries are required to conduct their own independent evaluation to determine which investments may be prudently included in the plan's menu of options. See 575 U.S. at 529–530. If the fiduciaries fail to remove an imprudent investment from the plan within a reasonable time, they breach their duty. See id.

The Seventh Circuit's exclusive focus on investor choice elided this aspect of the duty of prudence. For instance, the court rejected petitioners' allegations that respondents offered "investment options that were too numerous, too expensive, or underperforming" on the same ground: that petitioners "failed to allege ... that Northwestern did not make their preferred offerings available to them," and simply "object[ed] that numerous additional funds were offered as well." In the court's view, because petitioners' preferred type of investments were available, they could not complain about the flaws in other options. The same was true for recordkeeping

fees: The court noted that "plan participants had options to keep the expense ratios (and, therefore, recordkeeping expenses) low." Thus, "[t]he amount of fees paid were within the participants' control."

Given the Seventh Circuit's repeated reliance on this reasoning, we vacate the judgment below so that the court may reevaluate the allegations as a whole. On remand, the Seventh Circuit should consider whether petitioners have plausibly alleged a violation of the duty of prudence as articulated in *Tibble*, applying the pleading standard discussed in *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007). "Because the content of the duty of prudence turns on 'the circumstances ... prevailing' at the time the fiduciary acts, § 1104(a)(1)(B), the appropriate inquiry will necessarily be context specific." *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014). At times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise.

The judgment of the Seventh Circuit is vacated, and the case is remanded for further proceedings consistent with this opinion.

NOTES AND QUESTIONS

1. *Brokerage Accounts as Investment Options.* How does *Hughes* impact the fiduciary responsibilities associated with the administration and management of participant-directed 401(k) plans that offer a brokerage account as an investment option? Does the plan's fiduciary only have to monitor the fees associated with the brokerage account itself, or does the plan fiduciary also have to monitor the fees associated with the investments offered through the brokerage account (which could number in the hundreds, as illustrated by the facts of *Hughes*)?

2. *Pleading Excessive Fee Claims.* At the end of *Hughes*, the Supreme Court instructs lower courts to apply the standard set forth in *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007) for a motion to dismiss a claim under Federal Rule of Civil Procedure 12(b)(6). Under the *Iqbal/Twombly* standard, which is "context-specific," the "courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes*, 142 S. Ct. at 742. At the pre-discovery pleading stage, how is the plaintiff able to plead facts beyond a comparison of funds and fees that incorporate the specific trade-offs considered by the fiduciary? See Albert v. Oshkosh Corp., 47 F.4th 570 (7th Cir. 2022) (dismissing plaintiff's claims of excessive recordkeeping and mutual funds fees for failing to provide meaningful comparisons and context regarding services provided).

CHAPTER SIX

B. THE "NUTS AND BOLTS" OF ERISA LITIGATION

3.a Statutes of Repose and Limitations (p. 571-72)

Insert the following paragraph after the carryover paragraph at the top of p. 572:

In *Intel Corporation Investment Policy Committee v. Sulyma*, 140 S. Ct. 768 (2020), the Supreme Court held in a unanimous decision that a participant will not be deemed to have "actual knowledge" of a fiduciary breach under the shorter three-year statute of limitations period of subsection 413(2) if the participant did not read, or could not remember reading, disclosures made to them in accordance with ERISA requirements. Thus, the six-year statute of repose under subsection 413(1) applied to the participant's lawsuit.

D. SECTION 502(A)(2) CLAIMS: BREACH OF FIDUCIARY DUTY

2. Measuring Investment Losses

Delete Note 3 on p. 638-39 and insert the following:

3. *Participant Standing to Bring Breach of Fiduciary Duty Claims for Investment Losses in a Defined Benefit Plan.* In *Thole v. U. S. Bank,* 140 S. Ct. 1615 (2020), two retired participants in a defined benefit pension plan sponsored by U.S. Bank filed a class action against U.S. Bank and the plan's fiduciaries, alleging that a failure to prudently manage the plan's investments (including investments in U.S. Bank's proprietary mutual funds) between 2007 and 2010 caused losses to the plan of approximately $750 million. Notably, the two retirees who brought the class action "had been paid all of their monthly pension benefits…and they are legally and contractually entitled to receive those same monthly payments for the rest of their lives." 140 S. Ct. at 1618

In a 5-4 decision, the Supreme Court held that the retiree-plaintiffs did not have standing under Article III of the Constitution to bring a claim for breach of fiduciary duty under Section 502(a)(2) because the outcome of the litigation would have no effect on their right to receive "fixed" future payments from the plan. As Justice Kavanaugh, the author of the majority opinion, described the facts, the plaintiffs would not receive "a penny more" in benefits if they won the lawsuit, and the plaintiffs would not receive "a penny less" if they lost. Thus, the majority

concluded that the plaintiffs lacked the "injury in fact" required to establish standing under Article III.

After *Thole*, what would be required for a participant or retiree to bring a breach of fiduciary duty claim for imprudent decisions that caused investment losses in a defined benefit plan? Although the Court did not directly answer this question, the majority opinion stated that "a bare allegation of plan underfunding [due to investment losses allegedly caused by imprudent fiduciary decisions] does not itself demonstrate a substantially increased risk that the plan and the employer would both fail." 140 S. Ct. at 1622. This statement suggests that even if the allegedly imprudent investment decisions caused the plan to be *underfunded*, pleading these facts alone may be insufficient for purposes of Article III standing. Rather, plaintiffs in the future may have to plead that the fiduciary breach also put the employer at *risk of default* and unable to fulfill its future funding obligation to the defined benefit plan, thereby causing the plaintiffs' "fixed" benefit payments (current or in the future) to go unpaid.

CHAPTER SEVEN

A. THE EARLY PREEMPTION CASES

Delete Note 2 on p. 734.

C. MODERN PREEMPTION JURISPRUDENCE

Insert the following note after Note 4 on p. 759:

5. *State Regulation of Pharmacy Benefit Managers.* As plans increasingly have utilized pharmacy benefit managers (PBMs) to control rising drug costs, many states have responded lobbying by pharmacies by seeking to regulate PBM practices and procedures. In *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020), the Supreme Court unanimously held that ERISA does not preempt an Arkansas law regulating PBMs by creating a process for pharmacies to challenge a PBM's below-cost reimbursements for dispensing generic drugs. The Supreme Court determined that—consistent with *Travelers*—the Arkansas law's regulation of PBM practices and procedures did not have an "impermissible connection" on the administration of ERISA plans. The outcome in *Rutledge* encourages states to continue to be aggressive in regulating PBMs and related prescription drug reimbursements to pharmacies.

Insert at p. 857

APPENDIX E

LIMITS ON CONTRIBUTIONS AND BENEFITS (2023)

Maximum annual benefit payable from a defined benefit plan (Code § 415(b)(i)(A))	**$265,000**
Maximum annual contribution amount (including forfeitures) to a participant's defined contribution plan account (Code § 415(c)(i)(A))	**$66,000**
Maximum amount for traditional and safe harbor 401(k) plan elective salary deferral contributions (Code § 402(g)(1))	**$22,500**
Maximum amount for traditional and safe harbor 401(k) plan catch-up contributions for participants age 50 or older (Code § 414(v)(2)(B)(i))	**$7,500**
Maximum amount for SIMPLE 401(k) plan elective salary deferral contributions (Code § 408(p)(2))	**$15,500**
Maximum amount for SIMPLE 401(k) plan catch-up contributions for participants age 50 or older (Code § 414(v)(2)(B)(ii))	**$3,500**
Limit on compensation amount used to determine plan contributions or benefits (Code § 401(a)(17))	**$330,000**
Highly compensated employee (Code § 414(q))	**$150,000**
Key employee status for top heavy testing:	
1% owner (Code § 416(i)(1)(A)(iii))	**$150,000**
Officer (Code § 416(i)(1)(A)(i))	**$215,000**
Social Security taxable wage base	**$160,200**

Health savings accounts (Code § 223)	
Minimum HDHP deductible amount for individual/family coverage	**$1,500/$3,000**
Maximum annual contribution to an HSA for individual/family coverage	**$3,850/$7,750**
Maximum annual catch-up contribution (age 55 or older)	**$1,000**
Maximum annual out-of-pocket amount for individual/family coverage under a HDHP	**$7,500/$15,000**
Maximum annual out-of-pocket amount for individual/family coverage under an ACA-compliant health plan	**$9,100/$18,200**
Limit on employee deferrals to healthcare or dependent care FSAs	**$3,050/$5,000**
Maximum carryover amount for healthcare FSAs	**$610**