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RETIREMENT PLAN DEVELOPMENTS

Second Circuit Allows IBM Stock-Drop Case to Proceed (Again)

On remand from the Supreme Court, the Second Circuit Court of Appeals reinstated its original judgment in the stock-drop case *Retirement Plans Committee of IBM v. Jander.* The case will go back down to the district court for further proceedings.

As we reported earlier this year, the Supreme Court vacated the Second Circuit's decision and remanded the case after the plan fiduciaries and the federal government raised arguments not presented to the Second Circuit. The Supreme Court had agreed to review what it takes for stock-drop plaintiffs to plausibly allege an alternative action that a prudent fiduciary "would not have viewed as more likely to harm the fund than help it," as required by *Fifth Third Bancorp v. Dudenhoeffer.* However, the fiduciaries and the government instead argued that the Employee Retirement Income Security Act (ERISA) does not require employee stock ownership plan fiduciaries to act on inside information, and if ERISA did impose a duty to disclose inside information not otherwise required to be disclosed under securities laws, such a duty would conflict with those laws.

After reviewing briefs on these issues, the Second Circuit reinstated the judgment from its original opinion. According to the court, it had either already considered the arguments raised in the briefs and would not revisit them, or the arguments were not properly raised and therefore forfeited.

In its original opinion, the Second Circuit reversed the district court's dismissal of the case and remanded for further proceedings after finding that the participants satisfied the *Dudenhoeffer* pleading standard. The Second Circuit found that several factual allegations satisfied the participants' burden, including the fiduciaries' alleged knowledge of and power to disclose the artificial price inflation and the reputational hit the company took after the information came out. The Second Circuit emphasized the participants' claim that the fiduciaries knew that eventual disclosure was inevitable, and therefore earlier disclosure would have been less harmful than later disclosure.

Eighth Circuit Upholds Dismissal of Wells-Fargo Stock-Drop Case

In contrast to the Second Circuit opinion in *Jander*, the Eighth Circuit ruled in late July that the plaintiffs in a stock-drop case against Wells Fargo did not satisfy the *Dudenhoeffer* pleading standard. Like the plaintiffs in *Jander*, the plaintiffs in *Allen v. Wells Fargo & Company* argued that under general economic principles, the longer the company concealed its now widely known unauthorized account fraud, the greater the harm to the company's reputation and stock price. However, the Eighth Circuit found that argument too generic and concluded that while earlier disclosure may have helped, it was not so clearly beneficial that a prudent fiduciary could not conclude that it would be more likely to harm the fund than to help it. In so ruling, the Eight Circuit aligned itself with the Fifth, Sixth and Ninth Circuits.

PBGC Provides COVID-19-Related Guidance for Single-Employer Pension Plans

The Pension Benefit Guarantee Corporation (PBGC) published question-and-answer guidance for single-employer pension plans in light of the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the COVID-19 pandemic. The guidance focuses on reportable events for missed contributions and the calculation of a plan's variable rate premium (VRP). The guidance also confirmed that the PBGC is continuing its operations, and encouraged plan sponsors that intend to file a distress termination to schedule a pre-filing conference.

Reportable Events – Missed Contributions

The CARES Act extended the due date for required contributions (including quarterly contributions) that would otherwise have been due in 2020 until January 1, 2021. The PBGC therefore clarified that no PBGC reportable event occurs if plan sponsors make minimum required contributions by January 1, 2021. The guidance also describes when PBGC reporting is due and what forms must be used if the plan sponsor fails to make required contributions by January 1, 2021.

Variable Rate Premiums

Under PBGC regulations, the assets used to determine a plan's VRP include the discounted value of prior year contributions to the extent the plan receives them by the date the administrator files the premium. As a result of the CARES Act, required contributions that are normally due before the premium filing deadline (October 15, 2020 for a calendar year plan) are now due after such date (January 1, 2021). According to the guidance, these two rules taken together mean that

calendar year plans have until October 15, 2020, to make prior year contributions that will be reflected in the VRP calculation. Normally calendar year plans would have had until September 15, 2020, to make such contributions and include them in the VRP calculation.

However, the guidance notes that if a plan sponsor contributes for the prior year after filing the premium, it cannot amend the filing to increase the originally reported asset value to reflect the contribution and then request a refund.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Supreme Court Upholds Religious and Moral Exemptions to Contraceptive Coverage

The Supreme Court of the United States upheld regulations that exempt certain plan sponsors with religious or moral objections to providing contraceptive coverage from the requirement to do so under the Affordable Care Act (ACA). In its decision, *Little Sisters of the Poor Saints Peter and Paul Home v. Pennsylvania*, the Supreme Court decided two cases that began when the U.S. Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (collectively, the Departments) published interim final rules providing for the religious and moral exemptions in 2017. The Departments finalized the rules in November 2018, but a nationwide preliminary injunction made them ineffective. The Supreme Court's decision reverses the injunction and rules that the Departments had the authority under the ACA to create the exemptions, and that they were made in accordance with the Administrative Procedure Act.

The Supreme Court reasoned that the Departments had the authority to create the exemptions because, under the ACA, non-grandfathered group health plans must provide women with preventive care "as provided for" in guidelines supported by the Health Resources and Services Administration (HRSA), an agency within HHS. The phrase, "as provided for," not only grants HRSA authority to define the preventive care services for women, but also empowers HRSA to create exemptions from the preventive care services.

Accordingly, the regulations that provide for the religious and moral exemptions can be relied upon once again. For group health plans, the religious exemption generally applies where the plan is established or maintained by a non-governmental plan sponsor that objects to covering some or all contraceptive services based on sincerely held religious beliefs. The moral exemption applies to plans sponsored by nonprofit organizations, potentially including unions and

multiemployer plan sponsors, or for-profit entities with no publicly traded ownership interests that object to coverage based on sincerely held moral convictions.

ACA Affordability Percentage for Health Coverage Announced for 2021

The Internal Revenue Service (IRS) announced that the ACA's affordability percentage for plan years that begin in 2021 will increase from 9.78 percent to 9.83 percent. Under the ACA, an applicable large employer is generally required to offer at least one level of health plan coverage that provides affordable, minimum value coverage to its full time employees. "Affordable" coverage means the premium for self only coverage cannot be greater than the designated percentage of the employee's household income. Plan sponsors should review the affordability of their health plan coverage and ensure additional employer contributions are not required.

Final Rule on Confidentiality of Substance Use Disorder Records Inches Closer to HIPAA

The Substance Abuse and Mental Health Services Administration (SAMHSA) and HHS published a final rule revising the confidentiality protections for substance use disorder patient records under 42 CFR Part 2 (Part 2). The Part 2 rules are distinct from the privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Although a majority of the Part 2 rules apply to treatment programs, some apply to third-party recipients of patient information, including health plans.

SAMHSA has updated the Part 2 rules several times to reflect changes in health care and to bring them closer to HIPAA. This final rule continues that effort. However, parts of the final rule will have a limited lifespan, as the CARES Act amended the statute that underlies Part 2 to align the Part 2 confidentiality standards more closely with HIPAA. HHS will publish a separate rule implementing the CARES Act changes.

The present final rule does not substantively change the requirements for health plans under the Part 2 rules. However, it does clarify some points relevant to plans:

1. Records for payment or health care operations may be re-disclosed to contractors, subcontractors or legal representatives for those activities without additional patient consent.

2. The final rule adds a list of payment and health care operation example

activities, which are similar to the activities included under HIPAA than under prior guidance.

3. Third-party payers may receive records without patient consent to perform audits and evaluations to improve patient care and outcomes; manage resources; adjust payment policies to enhance care or coverage; or review medical necessity, medical appropriateness or utilization.

The final rule takes effect on August 14, 2020.

Proposed Rule Would Help Plans Retain Grandfathered Status

The Departments proposed a rule to make it easier for grandfathered health plans to keep that status under the ACA. Under the proposed rule, plans would have greater flexibility to increase fixed cost-sharing requirements, such as copayments, deductibles and out-of-pocket maximums. The proposed rule would also ensure that grandfathered high deductible health plans (HDHPs) can comply with the Internal Revenue Code's minimum deductible requirements without losing their grandfather status.

There are six types of changes, measured from March 23, 2010, that will cause a loss of grandfather status. The proposed rule affects two of these types of changes:

1. Those due to a fixed amount cost-sharing requirement, other than a copayment (such as a deductible or out-of-pocket maximum), increasing by more than the "maximum percentage increase;" and

2. Those due to a fixed amount copayment increasing by more than the maximum percentage increase or, if greater, five dollars increased by medical inflation.

The proposed rules provide an alternative definition of "maximum percentage increase" based on the premium adjustment percentage, which the Departments announce annually. The current rules define the maximum percentage increase as medical inflation measured from March 23, 2010, plus 15 percentage points. Under the alternative definition, maximum percentage increase may be the portion of the premium adjustment percentage that reflects the relative change between 2013 and the calendar year before the effective date of the increase (that is, the premium adjustment percentage minus 1), expressed as a percentage, plus 15 percentage points.

The Departments believe the alternative definition of maximum percentage increase would allow plans to make larger changes to their cost-sharing requirements. Plans could rely on either definition.

The Departments are accepting comments on the proposed rule through August 14, 2020. They are expected to finalize the rule before the end of the year.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

COVID-19 Public Health Emergency Declaration

The secretary of HHS renewed the public health emergency declaration for COVID-19 effective as of July 25, 2020. The public health emergency will continue through October 22, 2020, unless extended or terminated earlier. The duration of the public health emergency is relevant for provisions under the Families First Coronavirus Response Act and the CARES Act.

General Benefits

1. **Form 5500 Filing Deadline for Calendar Year Plans with Extensions**. For plans that obtained an extension, the Form 5500 must be filed by October 15, 2020.

2. **Summary Annual Report Deadline for Calendar Year Plans**. Plan administrators whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year end (*e.g.*, for plan years that ended December 31, 2019, the deadline is September 30, 2020). However, if a plan has received an extension for filing its Form 5500, the nine month deadline is extended by two months. Also, as explained in our May 2020 Benefits Counselor, the deadline for providing the summary annual report is tolled until 60 days after the announced end of the COVID-19 national emergency (the Outbreak Period), provided the plan administrator acts in good faith and provides the summary annual report as soon as administratively feasible.

3. **Summaries of Material Modifications for Calendar Year Plans**. Plan administrators generally have 210 days after the end of a plan year to provide a summary of material modifications (SMM). Thus, for a plan change adopted in 2019, the regular deadline to provide the SMM to participants was July 29, 2020. However, as with the deadline for the

summary annual report, the deadline for providing an SMM is tolled during the Outbreak Period.

Retirement Plans

1. **Annual Funding Notice**. Calendar year defined benefit plans with 100 or fewer participants generally must provide an annual funding notice to required recipients by the earlier of the Form 5500 due date or the date of the Form 5500 filing, including extensions. However, the deadline for providing the annual funding notice is tolled during the Outbreak Period.

2. **Determination Letter Deadline for Individually Designed Hybrid Plans.** Individually designed statutory hybrid pension plans, such as cash balance plans, that wish to obtain a determination letter under a limited term, expanded IRS program must a file Form 5300 by August 31, 2020.

Health and Welfare Plans

1. **Summaries of Benefits and Coverage.** Plan sponsors of group health plans must issue a new summary of benefits and coverage (SBC) to participants and beneficiaries covered under the plan in conjunction with open enrollment. Group health plans without open enrollment generally must issue the SBC no later than 30 days before the beginning of the plan year (December 1, 2020 for calendar year plans). However, the deadline for providing SBCs is tolled during the Outbreak Period. SBCs for plan years that start in 2021 must use a new model template and updated cost data from HHS for the coverage examples. While the changes to the template are minor, every coverage example will need to be recalculated due to the updated cost data, even if the cost-sharing requirements have remained the same.

2. **Health Reimbursement Arrangements**. Plan sponsors of health reimbursement arrangements (HRAs) integrated with other group health plan coverage must offer participants an annual opportunity to opt out of and waive all future reimbursements from their HRA. An opt-out notice can be provided with open enrollment materials to satisfy this requirement.