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RETIREMENT PLAN UPDATES

IRS FAQs Address Matching Contributions Related to Student Loan Repayments

On August 19, 2024, the Internal Revenue Service (IRS) issued Notice 2024 63 that provides guidance for plan sponsors with respect to match eligible student loan payments under the SECURE 2.0 Act. The guidance addresses issues that may arise for 401(k), 403(b), governmental 457(b) or SIMPLE IRA plans in administering such matching contributions, including: general eligibility, employee certification requirements and reasonable plan procedures. The guidance also describes special nondiscrimination testing relief applicable to student loan repayments. This guidance applies for plan years beginning January 1, 2025, while plan sponsors may rely on a good faith interpretation of the SECURE 2.0 Act for plan years beginning before January 1, 2025.

Another Class Action Lawsuit Regarding Improper Use of ERISA Forfeitures

Another national employer faces ERISA claims alleging misuse of retirement plan forfeitures. In a lawsuit filed on August 9, 2024, in federal court in California, participants of a Bank of America Corporation (BOA) 401(k) plan sued BOA for improperly benefitting from plan assets forfeited by employees who left employment with BOA. The plan document provided plan sponsor discretion in determining how to allocate forfeitures among permissible purposes. The complaint alleges that BOA consistently allocated the plan's forfeited funds to reduce its own contribution expenses without engaging in a reasoned decision-making process, which is in direct violation of ERISA's exclusive benefit rule. Two district courts, also out of California, have previously held that current and proposed regulations under SECURE 2.0 do not foreclose the claims and that if plan language gives discretion as to how to allocate forfeited contributions, the decision of how to allocate such forfeitures is a fiduciary function. While such lawsuits are still novel, plan administrators may want to evaluate how forfeitures are to be applied and how that allocation is described in plan documents.

Eleventh Circuit Deepens Circuit Split Regarding Burden of Proof for Excessive Fee Claims

The U.S. Court of Appeals for the Eleventh Circuit affirmed the decision of a

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district court in a 401(k) excessive fee lawsuit, ruling that participants had the burden of showing how the plan provider's conduct caused them to suffer any losses. *Pizarro v. The Home Depot, Inc.*, (11th Cir. Aug. 2, 2024). The plaintiffs alleged that the plan had excessive fees and imprudent investment options. The lower court granted summary judgment in the defendant's favor because the plaintiffs could not prove that they suffered any losses caused by a fiduciary's alleged breach. On appeal, the plaintiffs argued that Home Depot should have had the burden of proving that any plan losses were not caused by an alleged fiduciary breach. Citing legal precedent, ordinary principles of civil liability and ERISA's text, the Eleventh Circuit held that the plaintiffs had the burden of proving loss causation. While the Sixth, Seventh, Ninth, Tenth and Eleventh Circuits now have placed the burden of proof on participants, the First, Fourth, Fifth and Eighth Circuits—as well as the U.S. Department of Labor (DOL)—have argued that once an ERISA plaintiff has proven a breach of fiduciary duty and a related loss to the plan, the burden shifts to the fiduciary.

HEALTH AND WELFARE PLAN UPDATES

Seventh Circuit Addresses Plan Limitations for Autism Treatment under the MHPAEA

On August 5, 2024, the U.S. Court of Appeals for the Seventh Circuit, in *Hensen v. Group Health Plan Cooperative of South Central Wisconsin*, affirmed the lower court's ruling that the Mental Health Parity and Addiction Equity Act (MHPAEA) is not violated when coverage of a single type of mental health treatment differs from the coverage treatment for one type of medical benefit. The plaintiffs argued that the insurer's requirement for treatments to be "evidence based" was applied more stringently to mental health benefits for autism than to medical benefits.

The Seventh Circuit concluded that the plaintiffs' appeal failed because they only identified a single medical benefit that was handled differently from the mental health benefits sought in the suit. However, MHPAEA requires that treatment limitations applicable to mental health benefits be no more restrictive than treatment limitations "applied to substantially all medical and surgical benefits covered by the plan." The court acknowledged that "substantially all" is not defined for purposes of nonquantitative treatment limitations but concluded that it does not mean "one."

HHS Publishes Model Attestation Regarding HIPAA Reproductive Health Care Rule

In April 2024, the Office of Civil Rights (OCR) at the U.S. Department of Health and

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Human Services (HHS) issued final regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to establish new guardrails against certain uses and disclosures of protected health information (PHI) related to lawful reproductive health care. The regulations also require covered entities, including self insured group health plans and business associates, to obtain a completed and signed attestation in connection with requests for uses and disclosures of PHI that (1) are potentially related to reproductive health care; and (2) relate to health oversight activities, judicial and administrative proceedings (*e.g.*, subpoenas), law enforcement purposes, or disclosures to coroners or medical examiners.

HHS recently released a model attestation that covered entities and business associates may, but are not required to, use when requesting reproductive health information for the above purposes. The model attestation is intended to meet the regulatory requirements. Similar to a HIPAA authorization, this attestation for reproductive health care information can be obtained and executed electronically.

HHS Increases Civil Monetary Penalties for HIPAA, MSP and SBC Violations

HHS has released its annual inflation adjustments to civil monetary penalties. These adjustments apply to penalties assessed on or after August 8, 2024, for violations occurring on or after November 2, 2015.

The following key changes could affect sponsors of group health plans:

- **HIPAA Administrative Simplification**. The HIPAA administrative simplification rules include standards for privacy, security, breach notification and electronic health care transactions. HIPAA includes four tiers of culpability for violations. The indexed penalty amounts for each violation of a HIPAA administrative simplification provision are as follows:

Culpability	Minimum Penalty/Violation	Maximum Penalty/Violation	Annual Limit
Lack of Knowledge	**$141** (up from $137)	**$71,162** (up from $68,928)	**$2,134,831** (up from $2,067,813)
Reasonable Cause	**$1,424** (up from $1,379)	**$71,162** (up from $68,928)	**$2,134,831** (up from $2,067,813)

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Willful neglect, corrected within 30 days	**$14,232** (up from $13,785)	**$71,162** (up from $68,928)	**$2,134,831** (up from $2,067,813)
Willful neglect, not corrected within 30 days	**$71,162** (up from $68,928)	**$2,134,831** (up from $2,067,813)	**$2,134,831** (up from $2,067,813)

- **Medicare Secondary Payer (MSP)**. The indexed amounts for certain violations of the MSP rules applicable to group health plans are as follows:
  - Incentives. The maximum penalty for offering incentives to Medicare eligible individuals not to enroll in a group health plan that would otherwise be primary to Medicare is $11,524 (up from $11,162) per individual.
  - Nondisclosure. The daily maximum penalty for the failure of responsible reporting entities to provide information identifying situations where the group health plan is or was primary to Medicare is $1,474 (up from $1,428) for each failure.
- **Summary of Benefits and Coverage (SBC)**. A SBC generally must be provided to participants and beneficiaries before enrollment or re enrollment in a group health plan. The penalty for a health insurer's or non federal governmental health plan's willful failure to provide an SBC is $1,406 (up from $1,362) for each failure.

GENERAL DEVELOPMENTS

DOL Updates Cybersecurity Guidance for Employee Benefit Plans

In its continuing effort to protect U.S. workers' retirement and health benefits, the DOL updated cybersecurity guidance and confirmed that it applies to all ERISA-covered plans, including health and welfare plans. All ERISA-covered plans must implement appropriate best practices to help protect participants and their beneficiaries from cybercrime and emerging threats. See the Spotlight on the Department of Labor's Updated Cybersecurity Guidance for ERISA Plans.

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Sixth Circuit Reaffirms Limits on Mandatory Arbitration Provisions in ERISA Plans

In *Parker v. Tenneco, Inc.*, (6th Cir. Aug. 20, 2024), the U.S. Court of Appeals for the Sixth Circuit aligned with several sister circuits in limiting mandatory arbitration provisions that restrict, impede or waive statutory rights and remedies under ERISA. The plaintiffs claimed the plan fiduciaries mismanaged the plan's investment options and service providers. However, the plan sponsors sought to compel individual arbitration. On appeal, the Sixth Circuit affirmed the trial court's decision that the individual arbitration provision impermissibly limited participants' rights under ERISA.

Specifically, because the individual arbitration provision prohibited participants from recovering plan losses and restoring profits resulting from the fiduciary breaches, the court found that the provision functioned as a prospective waiver of the participants' substantive statutory remedies. This decision is a good reminder for plan sponsors to ensure that plan arbitration provisions are not too restrictive and do not otherwise impede or waive a participant's statutory rights and remedies under ERISA.

COMPLIANCE DEADLINES AND REMINDERS

General Compliance

Form 5500 Deadline for Calendar Year Plans with Extensions. Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2023, the Form 5500 filing deadline was July 31, 2024. However, for plans that obtained an extension, the Form 5500 must be filed by October 15, 2024.

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, 2023, the deadline is September 30, 2024). However, if a plan has received an extension for filing its Form 5500, the nine month deadline is extended by two months.

Retirement Plans

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 Form 5500 filing deadline, including filing extensions.

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QPAM Registration. The Qualified Professional Asset Manager (QPAM) Exemption, Class Prohibited Transaction Exemption 84 14, permits plan investment advisors who meet specified financial standards to act on behalf of plans and enter into transactions that would otherwise be prohibited under ERISA. In April 2024, the DOL adopted amendments to the QPAM Exemption dramatically effecting how certain managers operate. Plans relying on the QPAM Exemption on or prior to June 17, 2024, have until September 15, 2024, to notify the DOL via email of their QPAM status.

Health and Welfare Plans

Medicare Notice of Creditable Coverage. Plans that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether the drug coverage they have is creditable or non creditable by October 15, 2024. The Centers for Medicare and Medicaid Services have developed model disclosure notices.

Notice of Fixed Indemnity Excepted Benefits Coverage. Beginning in 2025, plan sponsors that offer hospital or other fixed indemnity benefits must provide a new consumer protection notice. The required notice is designed to highlight the differences between fixed indemnity products and traditional health insurance coverage and must be prominently displayed in any marketing, application and enrollment materials. The mandatory notice can be found online within the Short-Term, Limited-Duration Insurance regulations: 89 FR 23338, 234111.

These materials provide general information which does not constitute legal or tax advice and should not be relied upon as such. Particular facts or future developments in the law may affect the topic(s) addressed within these materials. Always consult with a lawyer about your particular circumstances before acting on any information presented in these materials because it may not be applicable to you or your situation. Providing these materials to you does not create an attorney/client relationship. You should not provide confidential information to us until Reinhart agrees to represent you.

Reinhart's Employee Benefits Practice is one of the largest and most tenured in the country:

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