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Benefits Counselor – Winter 2019 Update

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General Developments

Civil Penalty Amounts Revised for 2019

The Department of Labor ("DOL") issued a final rule setting forth its annual adjustments for civil monetary penalties, effective for penalties assessed after January 23, 2019. The following are the 2018 and 2019 civil monetary penalties applicable under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"):

General ERISA Requirements

Description of Violation	2018 Penalty Amount	2019 Penalty Amount
Form 5500. Failure or refusal to file Form 5500 annual report	$2,140 per day maximum	$2,194 per day maximum
Records and Reports. Failure to maintain records or furnish reports (*e.g.*, pension benefit statements) to certain former participants and beneficiaries	$29 per participant/beneficiary maximum	$30 per participant/beneficiary maximum
DOL Request. Failure to provide DOL with requested documentation	$152 per day, up to $1,527 per request	$156 per day, up to $1,566 per request

Retirement Plans

Description of Violation	2018 Penalty Amount	2019 Penalty Amount
Defined Contribution ("DC") Plan Auto Contributions. Failure of DC plan to provide notice of an automatic contribution arrangement	$1,693 per day per recipient maximum	$1,736 per day per recipient maximum
DC Plan Blackout or Divest Employer Securities. Failure to provide notices of blackout periods and of right to divest employer securities	$136 per recipient per day maximum	$139 per recipient per day maximum
Defined Benefit ("DB") Plan Distribution. Failure to properly distribute benefit from a DB plan with a liquidity shortfall	$16,499 per day maximum	$16,915 maximum
Single-Employer DB. Failure of single-employer DB plan to provide notice of funding-based limitation on certain forms of distribution	$1,693 per day per recipient maximum	$1,736 per day per recipient maximum
Multiemployer DB. Failure to disclose certain documents regarding multiemployer DB plan information and notice of potential withdrawal liability upon request	$1,693 per day maximum	$1,736 per day maximum
Multiemployer DB. Failure by an endangered status multiemployer DB plan to adopt a funding improvement plan or meet benchmarks	$1,344 maximum	$1,378 maximum
Multiemployer DB. Failure by a critical status multiemployer DB plan to adopt a rehabilitation plan	$1,344 maximum	$1,378 maximum
Cooperative & Small Employer Charity ("CSEC") Plan. Failure of a CSEC plan in restoration status to adopt a restoration plan	$104 per day maximum	$107 per day maximum

Health and Welfare Plans

Description of Violation	2018 Penalty Amount	2019 Penalty Amount
SBC. Failure to provide Summary of Benefits and Coverage	$1,128 per failure maximum	$1,156 per failure maximum
Form M-1. Failure to file Form M-1 for multiple employer welfare arrangement ("MEWA")	$1,558 per day maximum	$1,597 per day maximum
CHIP. Failure to provide CHIP/Medicaid Premium Assistance Notice	$114 per employee per day maximum	$117 per employee per day maximum
CHIP. Failure to provide information to State regarding benefits for Medicaid and CHIP-eligible individuals	$114 per participant/beneficiary per day maximum	$117 per participant/beneficiary per day maximum
GINA. Failure to comply with Genetic Information Nondiscrimination Act ("GINA")	$114 per participant/beneficiary per day maximum during non-compliance period	$117 per participant/beneficiary per day maximum during non-compliance period
GINA. Failure to comply with GINA, de minimis violation not corrected prior to DOL notice	$2,847 minimum	$2,919 minimum
GINA. Failure to comply with GINA, more than de minimis violation not corrected prior to DOL notice	$17,084 minimum	$17,515 minimum

GINA. Failure to comply with GINA, cap on unintentional failures	$569,468 maximum	$538,830 maximum

HEALTH AND WELFARE PLAN DEVELOPMENTS

Texas Federal District Court Rules ACA Unconstitutional

On December 14, 2018, a district court judge of the Northern District of Texas held in *Texas v. Azar* that the Affordable Care Act's ("ACA") individual mandate is unconstitutional and, consequently, the entire ACA is invalid. Shortly after Congress passed the Tax Cuts and Jobs Act ("TCJA"), which reduced the ACA's individual mandate penalty to zero effective January 1, 2019, several states and two individuals challenged the constitutionality of the ACA. The plaintiffs argued that in *Nat'l Fed'n of Indep. Businesses v. Sebelius* ("NFIB"), the U.S. Supreme Court determined that the individual mandate could be justified as a tax, but not as an exercise of Congress's authority under the Commerce Clause. Accordingly, plaintiffs claimed, with the individual mandate penalty now at zero, it could no longer be sustained as a "tax," leaving the provision without constitutional justification. Moreover, plaintiffs maintained, the remainder of the ACA is not severable from the individual mandate, causing the entire ACA to crumble.

The district court ruled in favor of the plaintiffs, holding that the ACA's individual mandate is unconstitutional because its tax component is removed on January 1. Further, the court viewed the mandate as "essential" to, and not severable from, the remainder of the ACA. As a result, the court declared the entire ACA invalid. However, the district court did not issue an injunction halting the enforcement of the ACA.

A coalition of states intervened in the lawsuit to defend the ACA's constitutionality. These intervenors argued that, in passing the TCJA, Congress intended only to remove the individual mandate and the only way to do so was to abolish the tax component, but not the entire ACA and, therefore, the balance of the ACA could be saved. However, unwilling to infer Congress's intent beyond providing tax cuts, the district court rejected these arguments.

In response to requests from the intervenor states, on December 30, the district court entered a partial final judgment of the December 14 order and issued a stay

of the order and of the remaining issues in the case—allowing an appeal of the December 14 decision. The intervenor states have appealed the decision to the Fifth Circuit Court of Appeals.

The December 30 order confirms that the ACA remains the law of the land while under appeal. Additionally, in a December 17 statement, the Department of Health and Human Services ("HHS") said it would continue enforcing all aspects of the ACA as it had before the December 14 decision.

EEOC Removes Incentive Provisions from Final Wellness Regulations

The Equal Employment Opportunity Commission ("EEOC") has issued final rules withdrawing the incentive provisions from its wellness regulations effective January 1, 2019. The rescission fulfills the EEOC's obligation under a district court's 2017 ruling in *AARP v. EEOC*, in which the court vacated the incentive provisions of the EEOC's final wellness regulations. The court determined the EEOC failed to sufficiently justify its determination that a 30% incentive rendered participation voluntary under the Americans with Disabilities Act ("ADA") and GINA.

According to the EEOC, until it can issue revised rules, it is withdrawing the vacated incentive provisions from the wellness regulations. As reported in our *November 2018 Benefits Counselor*, the EEOC intends to issue new regulations regarding wellness program incentives in June 2019.

The court order and EEOC's removal of the vacated provisions from the ADA and GINA wellness regulations do not affect other wellness program regulations, including the notice and disclosure requirements regarding wellness programs involving health risk assessments.

Health Plan Fiduciaries Liable for Tobacco Surcharge

The U.S. District Court for the Southern District of Indiana has ordered fiduciaries of the Dorel Juvenile Group Inc. Welfare Benefit Plan to repay over $145,000 to participants who paid tobacco premium surcharges. *See Acosta v. Dorel Juvenile Grp., Inc.* The lawsuit followed a DOL investigation finding that the company violated ERISA by discriminating against employees over a five year period by requiring them to pay tobacco surcharges under an impermissible wellness program. Specifically, the wellness program levied the surcharges without offering reasonable alternative standards or waivers as required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the ACA.

Though the company offered access to free smoking cessation classes, employees could not avoid the surcharge by simply participating in these classes.

In addition to repaying participants, the plan sponsor must pay nearly $15,000 in civil penalties to the DOL. The company also must revise its wellness program to comply with ERISA, which prohibits discrimination in eligibility and individual premium or contribution rates on the basis of any health status related factor.

As evidenced by this lawsuit, and other recent complaints alleging violations of the wellness program rules, the DOL is committed to enforcing wellness program rules that require plans to provide reasonable alternative standards to participants.

OCR Continues to Reach Settlement Agreements for HIPAA Violations

The Office for Civil Rights ("OCR") within HHS recently entered into two agreements to settle alleged violations of HIPAA Privacy and Security Rules. On December 5, 2018, the OCR announced that Advanced Care Hospitalists PL ("ACH") entered into a $500,000 settlement and resolution agreement over alleged HIPAA violations. According to OCR, ACH engaged an individual to provide billing processing services without entering into a business associate agreement ("BAA"). The individual represented himself as a Doctor's First Choice Billing ("First Choice") representative. However, First Choice had no record of the individual or his activities. ACH was later notified that patient information, including Social Security numbers, was viewable on the First Choice website. Besides the monetary settlement, ACH agreed to undertake a robust corrective action plan, including the adoption of BAAs, a company wide risk analysis, and comprehensive HIPAA policies.

Shortly thereafter, on December 11, 2018, the OCR announced another settlement agreement with a Colorado based hospital, Pagosa Springs Medical Center ("PSMC") for alleged HIPAA privacy and security violations. The settlement resolves a complaint asserting that a former employee had remote access to patients' ePHI on the hospital's web based scheduling calendar after terminating employment. The OCR's investigation revealed that PSMC impermissibly disclosed the ePHI of 557 individuals to the former employee and the web based calendar vendor without having a BAA in place. PSMC has agreed to pay $111,400 and to adopt a substantial corrective action plan.

These and other recent settlements signal the OCR's continued enforcement efforts with respect to HIPAA violations.

HHS Proposes to Rescind Standard Unique HPID and OEID

On December 19, 2018, HHS issued a proposed rule that would rescind the adopted standard unique health plan identifier ("HPID") and other entity identifier ("OEID"), along with related implementation specifications and requirements for their use. HHS adopted the HPID and OEID in a 2012 final rule but delayed enforcement of the regulations in 2014. Based on industry input, HHS determined HPID does not add value to electronic transactions or facilitate administrative simplification. HHS notes that the industry has satisfactory mechanisms to route claims and other HIPAA transactions using the existing Payer IDs and implementing the HPID would be "costly, complicated and burdensome."

OCR Requests Comments on Modifying HIPAA

The OCR of HHS issued a Request for Information ("RFI") soliciting public input on ways to modify HIPAA to further the goal of promoting coordinated, value based health care while preserving the privacy and security of PHI. The RFI requests information on any HIPAA Rules that present obstacles to these goals without meaningfully contributing to protecting PHI. The RFI also seeks comments on specific areas of the HIPAA privacy rule, including amending the rules to encourage or require covered entities to disclose PHI to other covered entities and accounting for disclosures of PHI for treatment, payment, and health care operations as required by the Health Information Technology for Economic and Clinical Health Act ("HITECH").

Michigan Health Insurance Claims Assessment Tax Officially Repealed

As reported in our *July 2018 Benefits Counselor*, Michigan repealed its Health Insurance Claims Assessment ("HICA") tax and replaced it with an Insurance Provider Assessment ("IPA") tax, contingent upon approval from the Centers for Medicare and Medicaid Services ("CMS"). On December 20, 2018, the Michigan Department of Treasury announced that CMS approved the IPA tax. Effective October 1, 2018, HICA is officially repealed and replaced by the IPA.

Subject to certain exceptions, Michigan's HICA tax applied to claims paid by group health plans, including insured and self funded plans. However, unlike HICA, self funded group health plans and their third party administrators ("TPAs") are not subject to the IPA tax. The IPA tax is levied upon health insurers, the cost of which will, presumably, be shifted to plan sponsors of fully insured plans. Additional guidance regarding the IPA is forthcoming.

HICA liability for 2018 should be computed on all "paid claims" prior to October 1, 2018. The filing deadline for the 2018 HICA annual return remains February 28, 2019. The final quarterly return was due to be filed on October 31, 2018.

Nationwide Injunction on Religious and Moral Exemption for Contraceptive Coverage

The U.S. District Court for the Eastern District of Pennsylvania issued a nationwide preliminary injunction of the final rules that would have exempted plan sponsors with religious or moral objections from the contraceptive coverage mandate under the ACA. The final regulations, which we reported in our *December 2018 Benefits Counselor*, were set to expand the religious exemption and create a moral exemption. The preliminary injunction affects non-grandfathered health plans, which must provide preventive care services mandated by the ACA, including contraception. The regulations were scheduled to become effective on January 14, 2019. The court issued the nationwide injunction one day after another federal district court issued a similar injunction preventing the final rules from taking effect in 13 states, plus the District of Columbia.

UHC Loses Cross-Plan Offsetting Case in Eighth Circuit

The Eighth Circuit Court of Appeals recently ruled against a group of United Healthcare entities (collectively, "UHC") in a case regarding their practice of cross-plan offsetting, which is also sometimes referred to as "bulk payment recovery" or "cross-plan subsidization." Insurers and TPAs use cross-plan offsetting as an overpayment recovery method. By engaging in cross-plan offsetting, the insurer or TPA recovers overpayments made to providers for claims submitted under one plan, by reducing the provider's payment for future claims submitted under a different plan. UHC began cross-plan offsetting in 2007 for both its insured plans and the self-funded plans it administers.

In the case against UHC, the Eighth Circuit determined that UHC's practice of cross-plan offsetting was impermissible under the terms of the relevant plan documents. The court found it persuasive that the plan documents were silent on the matter of cross-plan offsetting. Further, the court found that the language in the plans granting UHC broad administrative authority was not sufficient to authorize cross-plan offsetting.

The court also indicated that cross-plan offsetting could violate ERISA's fiduciary duty requirements and result in a prohibited transaction, although it did not directly rule on this point. The court considered that cross-plan offsetting

arguably amounts to failing to pay a benefit owed to a participant under one plan to recover money for the benefit of another plan. In addition, the court considered that cross-plan offsetting may effectively transfer money from one plan to another.

The Eighth Circuit's decision generally aligns with a DOL brief which it submitted as a friend of the court, except that the DOL brief more firmly asserted that cross-plan offsetting violates ERISA.

CMS and HHS Propose Maximum Annual Limits on Cost Sharing for 2020

CMS and HHS recently proposed that the maximum annual limitation on cost sharing for 2020 were $8,200 for self only coverage and $16,400 for other than self-only coverage. This represents an approximately 3.8% increase above the 2019 parameters of $7,900 for self-only coverage and $15,800 for other than self only coverage. CMS and HHS issued the proposed maximum annual cost-sharing limits as part of their proposed Notice of Benefit and Payment Parameters for 2020.

CMS and HHS Propose Excluding Drug Coupons from Out-of-Pocket Limit for Insurers

CMS and HHS published a proposed rule that would allow health insurance issuers to exclude certain drug manufacturer coupons from the annual cost-sharing limit. The rule, which was part of the agencies' proposed Notice of Benefit and Payment Parameters for 2020, would apply to amounts that insured patients pay toward cost sharing using any direct support from drug manufacturers to reduce their immediate out of-pocket costs for specific brand drugs with a generic equivalent. The agencies are seeking comments on whether the rule should only apply to qualified health plans issued by insurers on the Exchanges. Comments are due by February 19, 2019.

HHS Proposes Changes Affecting Drug Pricing, Including Manufacturer Payments to PBMs

HHS published a proposed rule intended to lower drug costs, in part by increasing transparency between pharmacy benefit managers ("PBMs") and their health plan clients and reducing the potential for kickbacks from the manufacturers to PBMs. To achieve these goals, the proposed rule would add a safe harbor to the regulations under the federal anti-kickback statute, section 1128B(b) of the Social Security Act, to protect certain fees that drug manufacturers pay to PBMs for

services PBMs render to the manufacturers that relate to their services to health plans (for example, manufacturers may pay PBMs for services that depend on or use data gathered by PBMs from their plan customers, such as claims data). HHS is concerned that these fees if calculated in certain ways, could function as a disguised kickback. The proposed rule would create a safe harbor to protect fee arrangements between PBMs and drug manufacturers that meet the following criteria:

- There is a written agreement between the PBM and the drug manufacturer that:
  - covers all of the services the PBM provides to the manufacturer in connection with the PBM's arrangements with health plans for the term of the agreement; and
  - specifies each service to be provided by the PBM and the compensation for such services.
- Compensation paid to the PBM is:
  - consistent with a fair market value in an arms-length transaction;
  - a fixed payment, not based on a percentage of sales; and
  - not to be determined in a way that takes into account the volume or value of any referrals or business otherwise generated between the parties, or between the manufacturer and the PBM's health plans, for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs.
- The PBM must disclose in writing to each health plan with which it contracts at least annually, and to HHS upon request, the services it rendered to each drug manufacturer related to the PBM's arrangements with that health plan and the associated costs for such services.

With regard to the last requirement, HHS takes the position that PBMs are agents of their health plan clients, and transparency is important to ensure that a PBM's arrangements with manufacturers are not in tension with the services that the PBM provides to the health plans. HHS is seeking comments on the transparency requirement, among other aspects of the proposal. HHS is also considering whether PBMs should have to disclose the fee arrangements to the health plans.

HHS noted that the proposed safe harbor would not preempt the terms of any contract between a PBM and a health plan that limits or delineates the PBM's use of the health plan's data. The proposal also would not affect the ability of health plans and PBMs to negotiate different disclosure provisions in their contracts.

Court Dismisses Residential Treatment Claims against Anthem

The U.S. District Court for the Southern District of Ohio dismissed claims against Anthem BlueCross and BlueShield ("Anthem") after it denied benefits for treatment based on a plan provision that excludes coverage for "wilderness camps." The plaintiff had sued under ERISA to recover benefits, as well as under the Parity Act for an impermissible nonquantitative treatment limitation.

The court dismissed the plaintiff's claim for benefits under ERISA because it could not find Anthem's interpretation of the plan's exclusion for wilderness camps arbitrary and capricious. The court considered that the plan excluded both "wilderness camps" and "outward bound programs," which indicated that the terms do not have the same meaning. The court also considered that the program provides treatment in the wilderness and refers to its setting as a "camp" on its website.

The court also dismissed the plaintiff's claims related to the Parity Act. The plaintiff alleged that the plan violated the Parity Act because it included services at intermediate facilities such as rehabilitation hospitals and skilled nursing facilities, but not wilderness camps. However, the court noted that the plan covers services at residential treatment centers for both medical and mental health services, and considered a residential treatment center an intermediate facility analogous to a rehabilitation hospital and skilled nursing facility. Accordingly, relying on other district court decisions, the court found that the plan did not violate the Parity Act by excluding services at wilderness camps because it covers both mental health and medical/surgical services at residential treatment centers.

The case is *A.G. v. Community Insurance Company d/b/a Anthem Blue Cross and Blue Shield*, No. 1:18 cv 300, 2019 BL 27136 (S.D. Ohio Jan. 28, 2019).

RETIREMENT PLAN DEVELOPMENTS

Second Circuit Revisits IBM Employees Dismissed Stock Drop Case

A panel of judges from the Second Circuit Court of Appeals recently reversed the dismissal of an ERISA "stock drop" lawsuit in *Jander v. Ret. Plans Comm. of IBM*. The

plaintiffs, as participants in IBM's 401(k) Plan who invested in company stock, claimed the company breached its duty to prudently manage the Plan's assets and adequately monitor the Plan's fiduciaries. They argued the defendants knew and should have disclosed to Plan participants, that the company's microchip division was overvalued and the failure to do so resulted in an artificially inflated company stock price that harmed participants. The district court dismissed the claims, concluding that a prudent fiduciary could have determined that earlier corrective disclosure would have done more harm than good.

The Second Circuit reversed and determined the participants stated a plausible claim for a violation of ERISA's duty of prudence. The court first reviewed the U.S. Supreme Court's Dudenhoeffer test, and explained the test was unclear because it initially asked whether a prudent fiduciary would not have viewed an alternative action as more likely to harm the fund than to help it, but later the court asked whether a fiduciary could not have concluded the action would do more harm than good. The latter formation, the court explained, appears to ask whether any prudent fiduciary could have considered the action to be more harmful than helpful. The use of the "could not have" phrase in the initial question suggests a more restrictive standard, which considers whether any prudent fiduciary could reach such a conclusion. However, the court found it unnecessary to resolve this dispute, because it found the participants' allegations satisfy both standards.

The court detailed several specific factual allegations that cumulatively satisfied the plaintiffs' burden, including that the fiduciaries' alleged knowledge of and power to disclose the artificial price inflation and the negative impact of the failure to disclose on the company's reputation. The court emphasized the participants' claim that the defendants knew that eventual disclosure regarding the failing division was inevitable, and therefore earlier disclosure would have been less harmful than later disclosure.

The Second Circuit is the first circuit court since Dudenhoeffer to allow a "stock drop" lawsuit to survive the motion to dismiss stage.

Ninth Circuit Addresses What Constitutes "Actual Knowledge" in ERISA Statute of Limitations Decision

The Ninth Circuit Court of Appeals reversed the dismissal of an ERISA breach of fiduciary duty action because the limitations period had expired in *Sulyma v. Intel Corp. Investment Policy Committee*. The plaintiff, a former employee and participant in Intel's retirement plan, alleged that the company breached its

fiduciary duties by imprudently investing in alternative investments and failing to monitor investment activities. The district court ruled the participant's claims were time barred under ERISA section 413, which provides that a plaintiff may not file suit more than three years after the earliest date the plaintiff had "actual knowledge" of a breach or violation. 29 U.S.C. § 1113(2).

On appeal, the Ninth Circuit examined whether there was a question of fact as to whether the participant had actual knowledge about the investments over three years prior to filing suit. Recognizing that confusion exists as to the scope of the "actual knowledge" standard, the court began its analysis by reviewing past cases applying this standard. The court further noted that ERISA section 413 originally contained a "constructive knowledge" standard but that language was later removed. Based on precedent and the current statutory language, the court concluded that "actual knowledge" does not equate to knowledge of the underlying transaction. Rather, the three year limitation begins to run once the plaintiff "has sufficient knowledge to be alerted to the particular claim." The court rejected Intel's argument that the participant knew of the alleged breach because Intel had disclosed information about the plan's investment activities in fund fact sheets as well as in postings on its website. The court determined there was a question of fact as to the participant's knowledge of the breach and remanded the case to the district court for further review.

In so ruling, the Ninth Circuit rejected the position taken by the Sixth Circuit Court of Appeals that. after receiving specific instructions on how to access plan documents electronically, a participant actually knew of the information contained in the documents.

IRS Issues Relief from "Once In, Always In" Condition of 403(b) Part Time Exclusion.

The Internal Revenue Service ("IRS") recently provided transition relief for Internal Revenue Code (the "Code") section 403(b) plans that incorrectly applied the "once in, always in" ("OIAI") condition under the "universal availability" rule to part time employees. See Notice 2018 95 (Dec. 4, 2018).

Under the universal availability requirement, if a section 403(b) plan permits some employees to make elective deferrals, all employees generally must be permitted to do so. However, the Code provides certain exceptions to this requirement, including an exception for part time employees who normally work fewer than 20 hours per week.

The IRS clarified that a part time employee may be excluded only if, in the initial 12 months of employment, the employee is reasonably expected to work fewer than 1,000 hours, and, in each exclusion year ending thereafter, the employee actually worked fewer than 1,000 hours in the prior year (this is referred to as the "OIAI rule"). Once the employee has worked 1,000 hours or more and is therefore permitted to make elective deferrals, the employee may not be excluded from making elective deferrals in subsequent years under the part time exclusion.

In response to comments indicating that many employers were unaware that the part time exclusion included the OIAI rule, and consequently improperly excluded part time employees, the IRS issued the Notice providing relief from the OIAI rule. The Notice includes relief regarding plan operations for a transition period, plan language relief and a "fresh start" opportunity.

- The relief period begins with tax years beginning after December 31, 2008 and extends through the last exclusion year that ends before December 31, 2019.
- Preapproved section 403(b) plans should have already incorporated the OIAI exclusion condition. Employers with pre-approved plans that incorrectly applied this exclusion have an operational error for which the Notice provides relief. Employers with individually designed plans have until March 31, 2020 (the end of the current remedial amendment period) to amend their plan to reflect the actual operation of the OIAI rule.
- The IRS also provides a "fresh start" opportunity under which a plan will not be treated as failing to meet the part time exclusion conditions for exclusion years beginning on or after January 1, 2019, provided the plan correctly applies the OIAI rule as if it became effective on January 1, 2018.

401(k) Sponsor Wins at Trial over Proprietary Mutual Funds

The U.S. District Court for the Western District of Missouri ruled that the fiduciaries of the 401(k) plan for American Century Services, LLC and its related companies (collectively, "American Century") did not breach their ERISA fiduciary duties by only offering affiliated funds in the plan. The case is the second of over 30 "affiliated funds" lawsuits filed since 2015 to go to trial.

The plaintiffs in the class-action claimed the fiduciaries breached their duty of loyalty under ERISA by only offering affiliated funds due to their desire to drive revenues and profits to American Century. However, the court did not find that

the fiduciaries prioritized American Century's interests over the participants'. Instead, the court found the fiduciaries believed that the American Century funds would most benefit participants. The court considered the following in reaching its decision:

- The fiduciaries' careful investigations of investment decisions;
- The fiduciaries' belief in the added benefit to participants due to the participants' familiarity with the funds, their ability to more closely monitor investments, and their direct access to fund managers for consultation;
- Participants' requests for different American Century funds to be added to the lineup, and the fiduciaries declining to always act on these requests;
- The small value of the plan's investments relative to all of American Century's assets under management (0.35%), which the court considered as evidence that the fiduciaries were not incentivized to "push" American Century's funds; and
- The lack of any benefit to the fiduciaries in their role as American Century employees based on the plan's lineup or performance.

The plaintiffs also alleged the fiduciaries breached their duty of prudence under ERISA because they engaged in a flawed process by only considering American Century funds. The court disagreed, finding that the selection of the lineup was prudent because it included diversified investment options. In addition, the court found it persuasive that, before and at each of their meetings, the fiduciaries compared each fund against funds from other companies to determine whether it remained a prudent investment.

The court further found that the fiduciaries did not act imprudently by taking the following actions: (1) excluding passive options and stable value funds; (2) including funds to hedge inflation; (3) including "too many" funds in the plan; (4) keeping certain funds on a "watch list" for multiple quarters despite poor performance; (5) retaining funds with allegedly excessive fees; (6) allowing a delay in converting funds to a lower-cost share class; and (7) not negotiating for rebates sooner. In each case, the court found that the fiduciaries followed a prudent decision-making process specific to the situation.

The case is *Wildman v. American Century Services, LLC*, No. 4:16-CV-00737-DGK, 2019 BL 21670, 2019 EBC 21670, 2019 US Dist Lexis 10672 (W.D. Mo. Jan. 23, 2019).

Outdated Actuarial Equivalence Factors Alleged to Cause Unduly Low Benefits

In the final weeks of 2018, participants in four large companies' pension plans (Metropolitan Life Insurance Company ("MetLife"), American Airlines, Inc. ("American"), PepsiCo, Inc. ("Pepsi"), and U.S. Bancorp ("U.S. Bank")) filed class action lawsuits alleging that their plans violate ERISA by using unreasonable actuarial equivalence factors for calculating joint and survivor annuities or early retirement benefits. The actuarial equivalence factors allegedly did not provide joint and survivor annuity or early retirement benefits that were the actuarial equivalent of the plan's default benefit, meaning participants who elected these forms of benefit received lower benefit payment amounts than they were due.

Two main law firms, Bailey & Glasser LLP and Izard Kindall & Raabe LLP, represent the plaintiffs in all four cases. The complaints generally allege that the plans' conversion factors, which include an interest rate and a mortality table, relied on outdated mortality assumptions and therefore did not produce the required actuarial equivalence.

The plaintiffs generally claim they received, and continue to receive, materially lower benefits than a true or reasonable actuarial equivalent. Thus, the plaintiffs claim they unknowingly forfeited and lost part of their vested benefits, which violates ERISA's anti-forfeiture rule and causes injury with each benefit payment. The plaintiffs seek reformation of their plans so they conform to ERISA, payment of future benefits under their reformed plans as required under ERISA, payment of amounts improperly withheld, and other equitable relief as the court sees fit.

PBGC Civil Penalties Increased for Inflation

The Pension Benefit Guaranty Corporation ("PBGC") has increased the maximum civil penalty amounts for the failure to provide certain notices or other information (e.g., reportable event filings, 4010 filings, certain multiemployer plan notices), effective for penalties assessed after December 28, 2018. The maximum daily penalty for failing to provide notices or other material information under ERISA section 4071 has increased from $2,140 per day to $2,194 per day. The maximum for failure to provide certain multiemployer plan notices under ERISA section 4302 has increased from $285 per day to $292 per day.

PBGC Makes Mediation Program a Permanent Option for More Cases

In October 2017, the PBGC launched a pilot Mediation Program, which offered

mediation for certain termination liability collection and Early Warning Program cases. Now, the Mediation Program is a permanent program that is also available for certain fiduciary breach cases. Mediation is voluntary and is offered by the PBGC to eligible respondents. Generally, cases will not be eligible if: (1) the plan sponsor has a minimal ability to pay, (2) there is a court proceeding pending, or (3) there is limited time to act and the plan sponsor has declined to sign a standstill or tolling agreement. The mediators are sourced from the Federal Mediation and Conciliation Service, and the PBGC and plan sponsors share the cost of mediation sessions.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Health and Welfare Plan Compliance Deadlines and Reminders

1. HIPAA Breach Reporting. Plans must file their annual breach reports with OCR by February 28, 2019. The annual breach report is for breaches involving fewer than 500 individuals that occurred during the preceding year. Breaches involving 500 or more individuals must be reported no later than 60 calendar days from the date of the breach's discovery.

2. Medicare Part D Creditable Coverage Disclosure. Calendar year plans providing prescription drug coverage must provide the annual creditable coverage disclosure to CMS by March 1, 2019 (or, for fiscal year plans, within 60 days after the beginning of the plan year).

3. Form M 1. Multiple employer welfare plans providing health coverage must e file the annual Form M 1 by March 1, 2019. Employers may request a 60 day automatic extension for the filing.

4. Forms 1095 B and 1095 C. Forms 1095 B and 1095 C must be annually distributed to participants and filed with the IRS. Plan sponsors of self funded health plans and Applicable Large Employers ("ALEs") must distribute Forms 1095 B and 1095 C to participants by March 4, 2019, and must file the same with the IRS by April 1, 2019 if e-filing (February 28, 2019 if filing by U.S. Mail).

5. Forms 1094 B and 1094 C. Plan sponsors and ALEs must file Forms 1094 B and 1094 C with the IRS by April 1, 2019 if e-filing (February 28, 2019 if filing by U.S. Mail). These forms serve as transmittal forms for

Forms 1095 B and 1095 C.