WINSTEAD

May Benefits Roundup

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The U.S. Department of Labor's Fiduciary Rule is Finally Dead or Is It?

The U.S. Department of Labor ("DoL") permitted the Fifth Circuit's decision overruling the fiduciary rule in its entirety on a nationwide basis due to failures in its promulgation to stand by permitting the deadline for asking for a rehearing to pass without any filing. While the U.S. Department of Labor (DoL)permitted the fiduciary rule to finally pass on, Attorneys General from three states and AARP filed separate requests with the Court to permit them to intervene and try to overturn the Fifth Circuit's decision. The deadline for the parties to request a rehearing before the full Fifth Circuit Court of Appeals judges has now passed without a request being filed by the DoL so the decision by the panel of three judges will stand. The Fifth Circuit denied both requests to intervene so neither group can seek the rehearing. So, the Fifth Circuit's decision is expected to become final on May 7. However, the decision could still be appealed by the DoL by filing a petition for certiorari with the U.S. Supreme Court; however, this is not likely, since the DoL did not seek rehearing and has announced its intent to not enforce the fiduciary rule.

The request to the U.S. Supreme Court to review the Fifth Circuit Court of Appeals' decision can be filed up until June 13. Once June 13 passes and if there are no petitions filed, then this version of the fiduciary rule is dead. Once June 13 passes, we wait for the next chapter in agency guidance. Plan sponsors and fiduciaries should not wait, but should consider:

- For plan sponsors, this means that any agreements that were updated for the fiduciary rule, such as moving to a platform product or a level fee type of safe harbor arrangement, are no longer required of the record-keeper to avoid the fiduciary rule's consequences. Plan sponsors who signed new service agreements proposed by plan service providers in response to the fiduciary rule may have more choices available to them now. Plan sponsors may want to contact their retirement plan record-keepers to determine if there might be other arrangements available to them now that overturning of the fiduciary rule is almost final.
- If a plan sponsor did not sign one of the proposed updated service agreements, it may still want to consider if it wants to investigate whether other terms may now be available as part of periodic due diligence to determine if its service providers continue to be prudent selections. Some vendors in preparation for the fiduciary rule's original effective date had restructured their service offerings and pricing to comply, so now that the fiduciary rule is not going to go into effect, there may be new choices and new pricing.
- For individuals, this means that there is no requirement that a broker provide them with expanded information or that the broker act in the individual's best interest when recommending investments, as the Best Interest Contract (or BIC) exemption requirements no longer apply to brokers. Instead, individual participants will need to manage the investment of their retirement plan account rollovers and IRAs on their own under the old, caveat emptor market rules, at least until the SEC moves forward on its proposals. Individuals may want to ask their IRA providers if there are other financial arrangements for their IRAs now that the fiduciary rule is gone.

Fiduciary Duties in Selecting Environmental, Social and Governance (ESG) Investment Funds for a 401(k) Plan (e.g., picking a fund that does not invest in alcohol, tobacco or firearm manufacturers or that does not pay interest or have debt securities)

Fiduciaries for retirement plans that permit individual participants to decide how to invest their retirement accounts may receive requests for the plan fiduciaries to add certain types of investment funds from participants. These frequently involve social causes (e.g., funds which preclude investment in manufacturers or retailers of guns, alcohol or tobacco) or funds that comply with religious requirements. Plan fiduciaries often struggle with whether such funds should be added to the investments funds available under the plan. While the U.S. Department of Labor had previously issued some guidance in this area, they recently released Field Assistance Bulletin No. 2018-01 ("FAB") in which they again addressed whether ESG considerations can be factors in selecting a fund.

The FAB states, “A fiduciary’s evaluation of the economics of an investment should be focused on financial factors that have a material effect on the return and risk of an investment based on appropriate investment horizons consistent with the plan’s articulated funding and investment policy.” (It is time to locate your funding policy and investment policy for the plan and review what they provide.) If otherwise collateral ESG issues present material business risks or opportunities to companies that need to be managed and that qualified investment professionals would treat as economic considerations under generally accepted investment theories, then the ESG factors may be more than mere tie-breakers. The primary considerations must be financial, return and risk and investment horizons consistent with the plan’s funding and investment policies.

A plan which selects an ESG investment alternative to offer as a fund in the line-up of the investment alternatives available to its participants may work if: (1) the line-up constitutes a broad range of investment alternatives, (2) the addition of that fund does not cause the plan to forego offering another alternative, and (3) the ESG investment is prudently selected, well managed and properly diversified.

In the case of a fiduciary selecting a qualified default investment alternative (QDIA), the QDIA regulation does not suggest that it should be selected based on collateral public policy goals. Instead it must be selected in compliance with the QDIA regulation’s requirements and in compliance with the plan’s investment policy.

- Plan fiduciaries should locate their funding policy and investment policy for the plan and review those to determine if they are up to date considering legal changes (e.g., they address QDIA selection or ESG investments or investment requests from participants) and changes in investments considered.
- Plan fiduciaries should also review their actual operations and the documentation of their operations contrasted with such policies.

The Government Accountability Office also has a report on ESG investing by retirement plans that is rumored to be issued soon.

MHPAEA Proposed Guidance and Class Action Risk

Recently, there have been a number of cases litigated regarding whether coverage of mental health and substance abuse treatments have complied with the Mental Health Parity and Addiction Equity Act (“MHPAEA”) requirements (residential treatment center and certain other therapy methods, including wilderness therapy). Some of these class actions have focused on lack of coverage for certain types of care.

In addition to the enforcement of the MHPAEA by class action and individual litigants, the U.S. Department of Labor (“DoL”) has also been auditing plans in this area and has found significant noncompliance amongst the plans subject to the MHPAEA (almost 50% of the plans audited were in violation). The violations the DoL found to be most frequent were, in this order: (1) non-quantitative treatment limits, (2) quantitative treatment limits, (3) and (4) (tied) annual dollar limits and cumulative treatment limits, and (5) benefit classification issues. MHPAEA enforcement is one of the Employee Benefit Security Administration’s top goals for 2018. Both the DoL and the U.S. Department of Health and Human Services (HHS) have established outreach efforts to persons who believe their mental health or substance abuse benefits were improperly denied. *The DoL’s Kansas City Regional office has also started an interagency initiative in the form of a task force to look at parity issues affecting access to treatment for opioid addition, and to look at the implications of the epidemic. The task force will look at the application of the MHPAEA to coverage of the treatment of opioid use disorders, including coverage of FDA-approved medications to treat such disorders.*

While plans may have been initially set up with a design intended to comply with the MHPAEA requirements, it is important to remember that compliance is tested based on utilization within the plan, how the various quantitative and qualitative treatment limitations are imposed and how the mental health and substance abuse limitations imposed compare to medical and surgical limitations imposed. This requires annual comparisons of how the various financial limitations are imposed in the various categories (6 originally with one subdivided) established in the regulations and sub-regulatory guidance to make the comparison.

More outreach from the DoL is planned for 2018, including a new issue of Warning Signs highlighting potentially impermissible limitations and particularly egregious non-quantitative treatment limitations (e.g., pre-service approval requirements or medical management requirements). The proposed FAQs on MHPAEA clarify that the DoL requires the plan terms as written and in practice to provide that any processes, strategies, evidentiary standards or other factors used

by a plan in applying a non-quantitative treatment limitation to mental health or substance abuse diagnosis must not be applied more stringently, unless clinically appropriate standards of care permit such a difference.

Employers with self-insured group health plans that provide any mental health or substance abuse benefits should consider contacting the plan's third party administrator to obtain an analysis of their plan's claims under the MHPAEA requirements for the prior plan year before starting work on designing their plan's benefits to ensure that the MHPAEA regulation requirements are satisfied with respect to the various types of quantitative limitations and with respect to the imposition of non-quantitative limitations.

California's Supreme Court's Reclassification of Outsourced Drivers as Employees, May Have Rippling Effects

Employers with operations in California should consider the implications of the California Supreme Court's decision on April 30, 2018 changing the test for determining if an individual is an employee or an independent contractor under California state law and if there is a risk with respect to their workforce as the decision implemented a new three pronged test. Reclassification of workers as employees can have a significant budgetary impact bringing claims for overtime and benefits. While most benefit plans for years have included what is commonly referred to as the Microsoft language following the U.S. Supreme Court's decision in *Vizcaino v. Microsoft Corp*. many years ago, some plans fail to include this language.

As time has passed, some plans have appeared that were drafted without this language, so it is good to review all your benefit plans regarding how they address the timing of eligibility of workers who are reclassified as employees. It is important to remember that the tax law standards for determining who is an independent contractor or an employee, while similar, are not identical to the standards under the federal Fair Labor Standards Act. We will need to wait to see what ripples may flow from the California decision in *Dynamex Operations West, Inc. v. Superior Court* as that court referred to statutory language in California of "suffer or permit to work", which bears a strong resemblance to the some of the statutory language in the federal Fair Labor Standards Act.

HSA Deduction Limit Reinstated for Family Coverage in 2018

First, the family deductible limit and the limit on contributions to the Health Savings Account (HSA) of a person whose only medical coverage was family coverage under a high deductible health plan was set at $6.900. Then the latest version of tax reform was enacted changing how such amount was calculated to consider inflation and reducing the limit to $6,850 earlier this year. The Internal Revenue Service heard that this presented problems for employers and individuals who had already started contributing toward the higher limit, and they issued new guidance effectively permitting those individuals whose only medical coverage is under a high deductible health plan for 2018 to use the $6,900 limit on their HSA contributions for 2018. The same rules regarding coordination of contributions by family members still apply, as this is a family deductible. If an employee has already contributed using the higher limit (and assuming they remain covered as eligible for the family limit through all of 2018), they will not be required to have the $50 difference in the limit refunded.

ADA and GINA Regulations from the EEOC on Wellness Programs

Last year, litigation overturned the EEOC's GINA and ADA regulation on limiting wellness program rewards. The EEOC was directed instead to update the court regarding when it would remedy the deficiencies in its regulatory process with respect to these regulations. The EEOC recently filed a status report indicating that it will not issue new proposed regulations addressing the deficiencies in the earlier regulation by the original date scheduled by the court for this August. Since there will be no new ADA and GINA proposed or final regulations on wellness programs by this August, it is highly unlikely that there will be any changes mandated to wellness programs for 2019. The regulatory process requires significant time.

Health Plan Security Risk Assessment Reminder from HHS

Earlier this week, HHS sent out an email update distinguishing between a risk analysis and a gap analysis and reminding all parties subject to the HIPAA Privacy and Security regulations that they are required to periodically perform a risk analysis. The risk analysis is to be a "thorough and accurate assessment of the risks and vulnerabilities to PHI." A risk analysis determines the vulnerabilities to PHI and then is used to make appropriate modifications to the ePHI system to reduce the risks to a reasonable and appropriate level.

The risk analysis identifies where protected health information (PHI) is received, transmitted or stored, who has access to such PHI. The risk analysis also identifies all of the locations and information systems where ePHI is created, received,

maintained or transmitted, including work stations and servers, mobile devices, electronic media, etc. The risk analysis must identify technical and non-technical vulnerabilities, assess current security measures (e.g., use of encryption and anti-malware solutions, implementation of security patches, and it must determine the likelihood and potential impact of a threat occurrence, determine the level of risk and document the completion of the risk analysis sufficiently to detail that it was accurate and thorough. The risk analysis is to be done periodically to ensure that new risks are identified and addressed in a timely manner.

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