Proskauer

ERISA Newsletter

Second Quarter 2020

Editors Overview

We kick off this edition of our Newsletter with an article that I co-authored with my partner, Paul Hamburger, explaining the doctrine commonly referred to as the fiduciary exception to the attorney-client privilege. The article provides a good refresher on fiduciary exception principles with updated case law, and provides practice points that can help employee benefits counsel and their clients better understand how best to protect the privacy of their communications.

There are several pieces of agency guidance that made the news this past quarter and that are discussed below. They include proposed and final guidance from the U.S. Department of Labor on the topics of ESG investing, fiduciary considerations for including private equity allocations in defined contribution plan investments, and electronic delivery of retirement plan disclosures. In addition, the DOL, IRS, and PBGC have issued COVID-19 related guidance. The Treasury Inspector General for Tax Administration also issued a report that offers helpful insights for employers who may be assessed shared responsibility payments because the IRS thinks they failed to offer adequate health coverage, as required by the Affordable Care Act.

The agency guidance, while important, should not overshadow the Supreme Court's decision in *Thole v. U.S. Bank*, where the Court concluded that the plaintiffs had no constitutional standing to pursue their challenges related to U.S. Bancorp's defined benefit plan. Other case law developments discussed in the Newsletter include decisions on 403(b) plan investment litigation, mental health parity, choice of law, fiduciary breach claims related to a single stock fund in a 401(k) plan, and retiree healthcare benefits.

Have a safe and healthy summer!

Fiduciary Exception to Attorney-Client Privilege for ERISA Plans*

By: Russell L. Hirschhorn and Paul M. Hamburger

This practice note explains the doctrine commonly referred to as the fiduciary exception to the attorney-client privilege. It is important for plan sponsors, fiduciaries, and their legal advisors to understand the rules regarding when the fiduciary exception doctrine can result in communications between a plan fiduciary and an attorney not to be privileged and become susceptible to being produced in litigation. This practice note also explains how the fiduciary exception doctrine has been used to try to obtain communications ordinarily protected by the attorney work product doctrine. The principles outlined in this practice note can help employee benefits counsel and their clients better understand how best to protect the privacy of their communications and how to anticipate when these communications may be open to examination by plan participants.

This practice note is organized in the following sections:

- General Principles Governing the Attorney-Client Privilege
- Identifying the Client in the Employee Benefit Plan Context
- The Fiduciary Exception to Attorney-Client Privilege
- Application of the Fiduciary Exception in Common Employee Benefit Situations
- Application of the Fiduciary Exception to the Attorney Work Product Doctrine
- Best Practices for ERISA Plan Sponsors, Fiduciaries, and Benefits Advisors for Navigating the Fiduciary Exception to the Attorney-Client Privilege

General Principles Governing the Attorney-Client Privilege

The attorney-client privilege refers to a legal privilege that serves to keep secret those confidential communications between an attorney and the attorney's client. It protects the fact that the communication took place as well as the substance of those communications. The privilege often is asserted in the face of a legal demand for documents or communications, whether as a discovery request from an opposing party in litigation or as a government request in the context of an investigation, audit, or other inquiry. Although such requests often do not surface until well after communications have taken place, it is important to always be thinking about whether communication is intended to be kept confidential.

The attorney-client privilege serves several purposes, including the primary purpose of encouraging the free flow of information between attorney and client. The U.S. Supreme Court has long recognized the importance of the attorney-client privilege. In Upjohn Co. v. United States, the Court observed:

The attorney-client privilege is the oldest of the privileges for confidential communications known to the common law . . . . Its purpose is to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice.

Upjohn Co. v. United States, 449 U.S. 383, 389 (1981).

For the attorney-client privilege to apply, there must be (1) a communication (2) made between privileged persons (3) in confidence and (4) for the purpose of obtaining or providing legal assistance for the client. Restat 3d of the Law Governing Lawyers, § 68. A communication is defined as "any expression through which a privileged person . . . undertakes to convey information to another privileged person and any document or other record revealing such an expression." Restat 3d of the Law Governing Lawyers, § 69.

Application in the Context of Employee Benefit Plans

Although ethical and privilege issues arise across all disciplines, they are particularly prevalent and tricky in their application to the employee benefits practice. When, for example, an ERISA plan fiduciary attends to a participant's claim for benefits under an employee benefit plan and wishes to consult an attorney for advice, those communications may not be protected from disclosure by the attorney-client privilege.

The challenge in the employee benefit plan context is to understand exactly when and how the attorney-client privilege will apply to the various scenarios encountered by the employee benefits advisor. The remainder of this practice note explores these questions and provides practical ideas to help benefit plan advisors and their clients best guard their communications.

Identifying the Client in the Employee Benefit Plan Context

The Employee Retirement Income Security Act (ERISA) is a federal law that protects the assets of millions of American workers who invest their funds in employer-sponsored retirement plans throughout their working lives to ensure that the funds will still be there when they retire. ERISA-covered plans operate as separate entities. At the same time, there are a number of parties related to these plans that provide the functional and logistical support that make these plans work and deliver the promised benefits. The attorney charged with representing the plan and its various related parties, therefore, must be clear on who in fact is the true client.

The starting point for analyzing attorney-client privilege issues is to understand that the privilege belongs to the client—and only the client—not the attorney. In the employee benefit plan context, this means two key things:

- First, it is important to understand who the client is. As discussed below, the client may be the employee benefit plan, the plan sponsor, or the plan fiduciary (among others). The failure to clearly identify the client could have significant ramifications in terms of whether communications that are intended to be privileged from third parties are in fact privileged.
- Second, a client can lose the privilege by allowing non-clients to participate in the communications that otherwise would be privileged (e.g., by permitting other non-clients "in the room" to hear that communication).

The Potential Clients

Three common potential clients in the context of employee benefit plans are (1) the plan itself, (2) the sponsor of the plan, and (3) fiduciaries of the plan.

Employee Benefit Plans

An employee benefit plan refers to an employee welfare benefit plan or an employee pension benefit plan, or a plan that is a combination of both. The plan is a separate and distinct legal entity that may sue or be sued as an entity. ERISA § 502(d) (29 U.S.C. § 1132(d)). That said, a plan as such does not transmit or receive communications other than through the parties who establish, manage, or administer the plan.

Plan Sponsors

The plan sponsor is typically the employer or employee organization (i.e., a union) that establishes the plan. Sponsors engage in settlor (as opposed to fiduciary) functions and are ultimately responsible for the plan's design decisions. When communicating with plan sponsors that operate through corporate entities, it is important to make sure that the *Upjohn* test (or state variation thereof) is satisfied. As provided for by the U.S. Supreme Court in *Upjohn Co.*, the attorney-client privilege applies to communications between a company employee and the attorney if all of the following are true:

- The communication involves information necessary for the attorney to provide legal advice to the company.
- The communication and information relate to matters within the employee's scope of employment.
- The employee making the communication was aware that the information was being shared with the attorney in order to provide the organization with legal advice.
- The communication was kept confidential and not disseminated beyond employees who, considering the corporate structure, need to know its contents.

449 U.S. at 383; see also, e.g., Fletcher v. ABM Bldg. Value, 775 F. App'x 8, 14 (2d Cir. 2019); In re Allen, 106 F.3d 582, 603 (4th Cir. 1997); United States v. Rowe, 96 F.3d 1294, 1297 (9th Cir. 1996). Importantly, unless agreed otherwise, a lawyer representing an organization represents the entity, not the employees or managers within that organization with whom the attorney might otherwise communicate.

In multiemployer plans, which cover employees represented by a union and involve more than one employer, the union and the employers are generally viewed as co-sponsors of the plan. For this purpose, the key distinction between the plan sponsor and plan fiduciaries is that the plan sponsor acts in a nonfiduciary (settlor) capacity—it is acting for itself and its own (plan sponsor) interests.

Plan Fiduciaries

The plan fiduciaries are responsible for managing and administering the plans, and they are required to act in the best interests of participants and their beneficiaries.

[A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

ERISA § 3(21)(A) (29 U.S.C. § 1002(21)(A)).

This definition is intentionally designed to be broad and can include the plan's named fiduciaries, administrators (including potentially the employer participating in the plan), trustees, and investment advisors. Regardless of who the fiduciaries are, they must nonetheless discharge their duties with respect to a plan solely in the interest of the participants and beneficiaries and for the exclusive purpose of administering their benefits.

The Fiduciary Exception to Attorney-Client Privilege

Under the fiduciary exception, legal advice provided to plan fiduciaries acting in their fiduciary capacity is not protected by the doctrine of attorney-client privilege and may be discovered by plan participants and beneficiaries (and those who stand in their shoes) in litigation. In reality, and as explained more fully below, the fiduciary exception is not really an exception as much as it is an application of the general rule that the privilege applies to communications with the client. The real clients to whom the privilege belongs in this view are the participants, and that is why they may be entitled to have access to the communications. But, as also explained below, there are limits to the exception. If, for example, the communication is made to a nonfiduciary client, like a plan sponsor operating in a nonfiduciary capacity, then the plan sponsor is the client and can expect to keep the communications privileged.

The Origins of the Fiduciary Exception

The fiduciary exception can be traced back to 19th century English common law in the case of Talbot v. Marshfield, 12 L.T.R. 761, 762 (Ch. 1865), where the court distinguished between two items of legal advice: one dispensed to trustees prior to any threat of suit, advising them regarding the propriety of paying advances to the children of the testator, and one dispensed after the commencement of suit, aimed at advising them "how far they were in peril." The court required the trustees to produce the first item but not the second.

As American jurisprudence developed over time, so did the fiduciary exception. One of the earliest American cases applying the exception to attorney-client privilege was Riggs Nat'l Bank v. Zimmer, in which the court required the production of a memorandum drafted by the trustee's counsel which addressed future potential tax litigation issues because the trust beneficiaries were ultimately the parties intended to benefit, not the trustees individually. Riggs Nat'l Bank v. Zimmer, 355 A.2d 709, 710 (Del. Chan. 1976). The court there referenced English common law when holding that whether or not disclosure of the memorandum would be allowed should be determined in light of the purpose for which it was prepared, the party(ies) for whose benefit it was procured, and whether it related to litigation which was pending or threatened.

The fiduciary exception as applied in the context of employee benefit plans is rooted in two distinct rationales:

- **The real client.** Some courts have endorsed the theory that, as a representative for the participants and beneficiaries of the plan which the fiduciary is administering, the fiduciary is not the real client. In this view, the fiduciary exception is not an exception to the attorney-client privilege; rather, it reflects the fact that, at least as to advice regarding plan administration, a fiduciary is not the real client and thus never enjoyed the privilege in the first place.
- **Duty to disclose.** Other courts have held that the fiduciary exception derives from an ERISA fiduciary's duty to disclose to plan beneficiaries all information regarding plan administration, particularly when it is the administration of the plan that is being challenged in the litigation. In such cases, the fiduciary exception can be understood as an instance of the attorney-client privilege giving way to a competing legal principle.

See, e.g., Wachtel v. Health Net, Inc., 482 F.3d 225, 234 (3d Cir. 2007); U.S. v. Mett, 178 F.3d 1058, 1064 (9th Cir. 1999).

Limitations on the Fiduciary Exception

Just as the attorney-client privilege itself has limitations, so too the fiduciary exception to the attorney-client privilege rule has its limits, including those discussed below.

Settlor Functions

To begin with, it is well established that the fiduciary exception has no applicability to settlor functions, such as plan design, amendments, and termination, because in such cases the true client is the plan sponsor, not the plan participants or beneficiaries. E.g., Bland v. Fiatallis N. Am., Inc., 401 F.3d 779, 787–88 (7th Cir. 2005) (holding that the fiduciary exception did not apply to communications regarding the termination or amendment of a plan); Wachtel, 482 F.3d at 225 (reasoning that the "fiduciary exception does not apply to settlor acts because such acts are more akin to those of a non-fiduciary trust settlor than they are to those of a trustee"); Feinberg v. T. Rowe Price Grp., Inc., 2019 U.S. Dist. LEXIS 217544, at *10 (D. Md. 2019) (holding that the fiduciary exception did not apply to minutes from a plan trustee meeting containing legal advice from in-house counsel regarding 401(k) plan design and amendments).

When the employer/plan sponsor is also the fiduciary, it is important to understand the capacity in which the employer is acting during the attorney/employer communication. As one court explained, "[t]he employer's ability to invoke the attorney-client privilege . . . turns on whether or not the communication concerned a matter as to which the employer owed a fiduciary obligation to the beneficiaries." Becher v. Long Island Lighting Co., 129 F.3d 268, 271 (2d Cir. 1997). In other words, if the employer acts in a nonfiduciary context as plan sponsor, communications between the employer and an attorney ought to retain the general attorney-client privilege. If the employer is acting in a fiduciary capacity during the communication, the fiduciary exception may very well apply.

This is why it can be important to clarify the context at the outset of a communication. For example, a memorandum or letter might have a legend that explains that the purpose of the communication between the employer and attorney is one between the employer acting as plan sponsor and not as plan fiduciary. The legend will not necessarily determine the final outcome if the facts are not consistent with the legend; nevertheless, it can help support a claim of privilege (and nonapplication of the fiduciary exception) if the legend is consistent with the nature of the underlying communication.

A best practice is to create an expectation of privilege and act accordingly. For example, where applicable, make clear on all written communications that they are protected by the attorney-client privilege and do not disclose them to other parties.

Good Cause Showing Requirement

Some courts have required a party seeking disclosure of what would otherwise be deemed privileged information to first establish good cause for requiring the production. E.g., In re Occidental Petroleum Corp., 217 F.3d 293, 298 (5th Cir. 2000) (requiring that documents be produced because plaintiffs had alleged breach of fiduciary duty claims sufficient to meet the good cause requirement); Chill ex rel. Calamos Growth Fund v. Calamos Advisors LLC, 2017 U.S. Dist. LEXIS 62565, at *3 (N.D. Ill. 2017) (finding that plaintiffs did not meet their burden to show good cause because they neglected to demonstrate necessity for the information and its unavailability from other sources).

Other courts, however, have rejected the good cause requirement. E.g., Hudson v. General Dynamics Corp., 186 F.R.D. 271, 274 (D. Conn. 1999) (concluding plan beneficiaries are not required to show good cause in order to invoke the fiduciary exception); Martin v. Valley Nat'l Bank, 140 F.R.D. 291, 326 (S.D.N.Y. 1991) ("the common-law principles governing required disclosure of trustee communications do not impose a 'good cause' limitation on this type of information").

Fiduciary Personal Liability

Under ERISA, fiduciaries are subject to personal liability in cases of fiduciary breach. In that context, courts recognize that fiduciaries ought to be able to retain and maintain privileged communications with counsel. E.g., Mett, 178 F.3d at 1066 (holding that the fiduciary exception did not apply to legal memoranda advising defendants, as plan trustees, about their personal, civil, and criminal exposure); Tatum v. R.J. Reynolds Tobacco Co., 247 F.R.D. 488, 498–99 (M.D.N.C. 2008) (concluding that the fiduciary exception was inapplicable to communications relating to an imminent lawsuit and the fiduciaries' concern for their own liability); Fischel v. Equitable Life Assur., 191 F.R.D. 606, 609–10 (N.D. Cal. 2000) (ruling that the fiduciary exception did not apply to legal advice provided to management concerning the potential liability for the employer-fiduciary). See Restat 3d of the Law Governing Lawyers, § 84 and cmt. b ("In a proceeding in which a trustee of an express trust or similar fiduciary is charged with breach of fiduciary duties by a beneficiary, a communication otherwise within § 68 is nonetheless not privileged if the communication: (a) is relevant to the claimed breach; and (b) was between the trustee and a lawyer who was retained to advise the trustee concerning the administration of the trust.").

Some courts have further explained that, in the absence of a "mutuality of interests" between the fiduciary and the plan beneficiaries regarding the purpose of the communications, the fiduciary exception to the attorney-client privilege does not apply and the fiduciary can have privileged communications with counsel. E.g., Wildbur v. Arco Chem. Co., 974 F.2d 631, 645 (5th Cir. 1992) (upholding a magistrate's finding that the fiduciary exception was inapplicable to communications from counsel to plan administrator concerning the defense of a pending lawsuit because there was no mutuality of interest creating a fiduciary relationship).

To determine whether a plan administrator was seeking legal advice in connection with plan administration and thus in a fiduciary capacity, courts generally look to "whether the interests of the fiduciary and the beneficiary had diverged at the time the communication occurred." Kushner v. Nationwide Mut. Ins. Co., 2018 U.S. Dist. LEXIS 119571, at *8–9 (S.D. Ohio 2018) (determining that the fiduciary exception did not apply because plan fiduciary "reasonably anticipated litigation" by engaging counsel from the beginning of the claims process). The underlying reasoning is applied uniformly across the courts in that the fiduciaries, acting in their personal capacity, are seeking legal advice on their own behalf and not on behalf of the participants.

The lesson for fiduciaries is to make the purpose of their communications with counsel clear. If the nature of the legal advice relates to personal liability of the fiduciary, to the extent possible make that clear before the communication is made.

Application of the Fiduciary Exception in Common Employee Benefit Situations

To further see how the attorney-client privilege rules and fiduciary exception apply in the employee benefit context, consider a few common scenarios.

General Advice/Advice at Meetings

By first answering the question of who the lawyer represents, lawyers and their clients—plan fiduciaries or employer-plan sponsors—can avoid getting tripped up on whether communications were or are privileged. On the one hand, when a lawyer represents a fiduciary, subject to the limitations on the application of the fiduciary exception, it can be expected that the communications with the fiduciary may be subject to disclosure to plan participants. On the other hand, when a lawyer represents an employer-plan sponsor, situations can get confusing rather quickly.

For example, a lawyer might be assisting the administrative personnel in human resources about plan-related issues, such as a plan-related compliance review, plan design-related questions, or legal compliance related matters. Care should be taken to separate clearly who the lawyer represents and for what purpose. By keeping clear lines of separation between fiduciary matters and plan sponsor matters, protected communications that are intended to be privileged can remain privileged and, moreover, attorneys and clients can avoid inadvertently tainting future communications.

Regardless of whether the lawyer represents the plan fiduciary, special care should be taken to avoid inadvertent waivers of the privilege. This can be particularly challenging in the context of meetings where the attorney and client will be accompanied by other parties. The problem arises because meetings often include attendees who are not clients, like actuaries, consultants, recordkeepers, and investment advisors or managers.

From a privilege perspective, the question is whether these third parties are necessary parties to the attorney in order for the attorney to render legal advice. For example, an attorney might have to answer a complex benefit question involving actuarial calculations. If the attorney needs actuarial help in order to formulate legal advice, the presence of the actuary might be necessary to the advice and not interfere with the application of the privilege. However, if the third parties at the meeting are not necessary for the lawyer's advice, any privilege that may have existed concerning a conversation between the plan fiduciaries and counsel may be waived by the mere presence of these non-client parties. E.g., Hill v. State Street Corp., 2013 U.S. Dist. LEXIS 181168, at *17–19 (D. Mass. 2013).

To avoid tainting application of the attorney-client privilege, take proper precautions at meetings where legal advice may be provided. If the intention is to have a privileged conversation, first remove unnecessary parties from the discussion.

Claims Process – Pre-decisional Communications

As explained above, one key issue in determining whether a fiduciary can have privileged communications with an attorney is whether the fiduciary's interests have sufficiently diverged from the participants' interests. This can be challenging when a participant has submitted a claim for review to the plan fiduciary and the fiduciary seeks legal advice related to the claim. In this context, courts must ascertain the point in time when the fiduciary's interests deviate from the interests of the participants. Unfortunately, it is not always clear when these previously mutual interests (i.e., the participants want benefits and the fiduciaries have to make sure benefits are provided in accordance with the plan) diverge into adversarial interests (i.e., the fiduciary has finally determined that the participant is not entitled to benefits).

Courts have held that interests only diverge sufficiently when there is a final denial of benefits. As such, pre-decisional communications between counsel and plan fiduciaries are more likely to be discoverable than post-decisional communications, when interests have clearly diverged. E.g., Stephan, 697 F.3d at 933 (requiring disclosure of advice regarding plan administration made before the final determination of the participant's claim); Wildbur, 974 F.2d at 631 (upholding a magistrate's decision requiring in-house counsel and plan administrators to testify in depositions regarding events and advice surrounding the decision to deny benefits to a beneficiary).

Courts tend to compel production of legal advice that the fiduciaries relied upon in crafting the adverse benefit determination due to the Department of Labor's regulations governing claims procedures. Those regulations require that a claimant be granted access to all documents and information relevant to the claim. 29 C.F.R. § 2560.503-1(h)(2)(iii). A document is relevant if it was "relied upon in making the benefit determination" or if it was "submitted, considered, or generated in the course of making a benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination." 29 C.F.R. § 2560.503-1(m)(8). As such, many of the communications between plan counsel and fiduciaries will become part of the administrative record, open to the claimant.

Many courts continue to draw a line at the fiduciary's final decision for purposes of determining whether interests have diverged. Nevertheless, there are still instances where a sufficiently adversarial relationship could arise even before the final decision denying benefits. E.g., Kushner, 2018 LEXIS 119571, at *10 (holding that the parties' interests had sufficiently diverged when the plaintiff was informed his claim would be denied before even submitting his claim); see also Christoff v. Unum Life Ins. Co. of Am., 2018 U.S. Dist. LEXIS 43535, at *23–24 (N.D. Minn. 2018) (holding the fiduciary exception applied to communications prior to the final benefits determination because "there was no request for advice connected to any pending legal action or a specific threat of litigation," despite plaintiff retaining an attorney during the claims process and disputing the plan's denial of information). In these cases, courts have taken a fact-intensive approach, considering factors other than timing, such as (1) the threat of litigation being more than a remote possibility, (2) the interests of the beneficiary and ERISA fiduciary diverging significantly, and (3) the necessity of the communications to the administrative claim process.

Claims Process – Post-decisional Communications

When a plan fiduciary seeks legal advice after it has denied a claim, these communications are generally protected by the attorney-client privilege, falling outside of the fiduciary exception. E.g., Moss v. Unum Life Ins. Co., 495 F. App'x 583, 595 (6th Cir. 2012) (ruling that the exception does not apply "to communications after a final decision" has been made or to communications "generated after the initiation of [a] lawsuit"); D.T. v. NECA/IBEW Family Med. Care Plan, 2018 LEXIS 155616, at *12 (W.D. Wash. 2018) (denying plaintiff's motion to compel communications that occurred after the final denial of the claim); Allen v. Honeywell Ret. Earnings Plan, 698 F. Supp. 2d 1197, 1201 (D. Ariz. 2010) ("The interests of the plan participants and plan administrators undoubtedly diverge sufficiently upon the final denial of an administrative claim . . . ."); Garemani v. First Unum Life Ins. Co., 2010 U.S. Dist. LEXIS 161151, at *9 (C.D. Cal. 2010) (holding that the fiduciary exception did not apply to documents generated after the final administrative decision). See also Carr v. Anheuser-Busch Cos., 791 F. Supp. 2d 672, 677 (E.D. Mo. 2011) (finding that communications that occurred before a final benefits determination was communicated were still privileged, in part, because at the time the communications occurred "the final decision to deny benefits had effectively been made"), aff'd, 495 F. App'x 757 (8th Cir. 2012).

Other Parties Involved in Benefit Disputes

Notably, courts also have held that the U.S. Department of Labor steps into the shoes of a participant for purposes of applying fiduciary exception principles. E.g., Donovan v. Fitzsimmons, 90 F.R.D. 583 (N.D. Ill. 1981) (concluding that a sufficient identity of interests existed to allow the Secretary of Labor to invoke the fiduciary exception).

Application of the fiduciary exception, however, is less certain when it comes to communications with insurers. Compare Stephan v. Unum Life Ins. Co. of Am., 697 F.3d 917, 932 (9th Cir. 2012) (finding no reason "why the disclosure of information is any less important where an insurer, rather than a trustee or other ERISA fiduciary, is the decisionmaker") with Wachtel, 482 F.3d at 238 (concluding that the real client was the insurer not the plan beneficiary).

Application of the Fiduciary Exception to the Attorney Work Product Doctrine

Separate from issues of attorney-client privilege, there is a doctrine known as the attorney work product doctrine. This rule operates similar to the attorney-client privilege in that it is intended to protect information, such as written or oral materials prepared by or for an attorney, in the course of legal representation, particularly in preparation for litigation. Fed. R. Civ. P. 26(b)(3). The work product doctrine actually provides broader protection in some respects than the attorney-client privilege. An adverse party, however, may discover or compel disclosure of work product upon a showing of substantial need to prepare its case if it cannot obtain the substantial equivalent by other means without undue hardship. Id.; see Hickman v. Taylor, 329 U.S. 495 (1947).

The general policy against invading the privacy of an attorney's course of preparation is so essential to an orderly working of our system of legal procedure that a burden rests on the one who would invade that privacy to establish adequate reasons to justify production through a subpoena or court order. Unlike the attorney-client privilege, the right to assert work product protection belongs principally, if not exclusively, to the attorney.

Several courts have addressed claims that discovery should not be permitted because the documents or information sought was protected by the attorney work product doctrine. Unsurprisingly, these courts have concluded that where the discovery sought is attorney work product, it will be protected from disclosure. E.g., Wildbur, 974 F.2d at 646 ("Because the attorney work-product doctrine fosters interests different from the attorney-client privilege, it may be successfully invoked against a pension plan beneficiary even though the attorney-client privilege is unavailable."); Aull v. Cavalcade Pension Plan, 185 F.R.D. 618, 629 (D. Colo. 1998) (concluding that documents exchanged between the plan, its outside counsel, and accountant concerning plaintiff's claims for breach of fiduciary duty, improper calculation and denial of benefits and other violations were protected by the attorney work product doctrine because they were prepared to assist counsel in anticipation of litigation); Everett v. USAir Group, Inc., 165 F.R.D. 1, 5 (D.D.C. 1995) (holding the plan sponsor could assert the work product privilege to the extent the participants' discovery requests called for documents that were prepared expressly in anticipation of litigation except insofar as they were prepared in anticipation of litigation on behalf of the beneficiaries).

Some courts leave the impression that they have created a fiduciary exception to the work product doctrine. Upon closer examination of those cases, though, it is more accurate to say that those courts simply took the position that the work product doctrine did not apply. E.g., Parneros v. Barnes & Noble, Inc., 332 F.R.D. 482 (S.D.N.Y. 2019) (holding that documents circulated among executives and reviewed by the general counsel were not attorney work product because there was no evidence to suggest the documents were prepared in anticipation of litigation); Geissal v. Moore Med. Corp., 192 F.R.D. 620 (E.D. Mo. 2000) (concluding that counsel's pre-decisional communications with plan fiduciary concerning a participant's claim for benefits were not protected by the work product doctrine because the communications occurred before the adverse decision was final and the divergence of interest occurred).

Best Practices for ERISA Plan Sponsors, Fiduciaries, and Benefits Advisors for Navigating the Fiduciary Exception to the Attorney-Client Privilege

Navigating issues of privilege can be a tricky endeavor and that is particularly true in the employee benefits arena. As explained in this practice note, the starting point is always to identify who is the client with whom the lawyer is communicating. Relatedly, consider the subject of the communications and the purpose for which the communications are being made. Such seemingly simple questions may sometimes be difficult to answer and may not always be so clear in hindsight. Benefits counsel and their clients will be well served to consider the following when communicating about issues pertaining to employee benefits:

- **Anticipate privilege issues.** Although requests for communications often do not surface until well after they have taken place, it is important to always be thinking about whether communication is intended to be kept confidential.
- **Who is the client?** The starting point for analyzing attorney-client privilege issues is to understand that the privilege belongs to the client—and only the client—not the attorney. It is therefore critical to identify at the outset who is the real client.
- **Create an expectation of privilege.** Where applicable, make clear on all written communications that they are protected by the attorney-client privilege and treat them as such.
- **Make the purpose of the communication clear.** If the nature of the legal advice relates to personal liability of the fiduciary, to the extent possible make that clear before the communication is made and keep such communications separate

from those that arguably invoke a mutuality of interest.

- **Take proper precautions when legal advice is being communicated**. If the intention is to have a privileged conversation, first remove unnecessary parties from the discussion.
- **Timing issue for benefit claim advice.** Pre-decisional communications between counsel and plan fiduciaries are more likely to be discoverable than post-decisional communications, where interests have clearly diverged.
- **Remember the attorney work product doctrine.** The attorney work product doctrine is generally effective at protecting communications between a plan fiduciary and attorney.

The authors thank Malerie Bulot and James Barnett, associates in the New Orleans office of Proskauer Rose LLP, for their assistance.

Highlights from the Employee Benefits & Executive Compensation Blog

403(b) Plans

Seventh Circuit Upholds Dismissal of 403(b) Plan Lawsuit Against Northwestern University in Apparent Split with Third Circuit

By: Myron Rumeld, Russell L. Hirschhorn, Tulio Chirinos and Benjamin Flaxenburg

Since the beginning of 2016, the ERISA plaintiffs' bar has filed nearly two dozen complaints targeting university-sponsored 403(b) plans. The majority of these lawsuits assert that plan fiduciaries breached their duties and engaged in prohibited transactions by (1) "packing" a plan with too many investment options that underperformed and were more expensive relative to other investment options, and/or (2) retaining too many record-keepers and paying record-keepers unreasonable fees. To date, these cases have had mixed results: some have been dismissed at the initial pleading stage, others have settled after the denial of motions to dismiss, and one was dismissed after trial. In a significant development, the Seventh Circuit recently issued its decision in the case against Northwestern University and, in doing so, became the first court of appeals to uphold the dismissal of such claims in their entirety. *Divane v. N.W.U.*, No. 18-2569, 2020 WL 1444966 (7th Cir. Mar. 25, 2020).

Participants in Northwestern University's 403(b) plans had alleged that the plan fiduciaries breached their fiduciary duties by: (1) entering a bundled service agreement with one of the plans' record-keepers that mandated the inclusion of a suite of the record-keepers' investment options, including some allegedly imprudent investment options; (2) maintaining multiple record-keepers and paying record-keeping fees through an asset-based arrangement instead of a flat per-participant fee; and (3) offering too many investment options where many underperformed readily available and cheaper alternatives. The complaint also had alleged that each of these fiduciary decisions violated ERISA's prohibited transaction rules.

On appeal, the Seventh Circuit affirmed the district court's dismissal of all claims and concluded that plaintiffs' claims did not assert plausible ERISA violations, but rather merely amounted to plaintiffs' "preference" for certain investment options and record-keeping arrangements. Before turning to the specific claims, the Seventh Circuit characterized plaintiffs' 287 paragraph complaint as "massive" and observed that the majority of the allegations complained about common plan practices not specific to the defendants or the plans, including paying record-keeping fees through revenue sharing and the offering of a wide range of investment options.

Turning first to the "bundled service agreement" claim, the Court concluded that the complaint itself undermined plaintiffs' claim that the plan fiduciaries breached their duties by entering into this agreement because the complaint acknowledged that one of the plans' best investment options, a traditional annuity, would not have been available absent the bundled service agreement. The Court also explained that nothing in the plans required participants to invest in the purportedly underperforming products and, moreover, plaintiffs failed to evaluate the decision to enter into a bundled service agreement against a relevant standard. Rather than allege what a "hypothetical prudent fiduciary" would have done differently, the complaint merely criticized Northwestern for making a rational business decision. The challenge to specific options included under the agreement also failed because, according to the Court, "it would be beyond the court's role to seize ERISA" as a means to eliminate those options disfavored by individual litigants where the plans also included the lower-cost, conservative options they preferred.

Turning next to plaintiffs' record-keeping fees claim, the Court explained that ERISA does not require (i) a plan to negotiate a record-keeping agreement that charges a fixed per-participant fee (as opposed to the asset-based agreement negotiated by Northwestern), or (ii) a plan to have one record-keeper or mandate a specific record-keeping arrangement. Furthermore, plaintiffs did not explain how it was better to have a fixed per participant fee and conceded that the plans had "valid reasons" for maintaining multiple record-keepers, including that doing so allowed the plans to include the various options preferred by participants.

The Court then addressed plaintiffs' claim that plan fiduciaries breached their duties by offering an investment lineup that contained an excessive number of expensive, underperforming options. The Court concluded that, even if plaintiffs were correct that the plans offered retail share class options with "layers of fees," this was not in and of itself sufficient to sustain a claim because plaintiffs failed to allege that the plans omitted their preferred low-cost index fund alternatives. The Court also held that "the ultimate outcome of an investment is not proof of imprudence" and plan fiduciaries "may generally offer a wide range of investment options and fees without breaching any fiduciary duty."

In reaching these conclusions, the Court briefly commented on plaintiffs' reliance on the Third Circuit's decision in *Sweda v. Univ. of Penn.*, No. 17-3244, 2019 WL 1941310 (3d Cir. May 2, 2019) and, in particular, plaintiffs' argument that the Third Circuit held that plan fiduciaries cannot satisfy their obligations by simply offering a wide range of investment options. The Seventh Circuit observed that the Third Circuit's ruling merely held that offering a wide range of investment options in and of itself did not insulate fiduciaries from misconduct and that, in addition to evaluating the plan as a whole, courts must also consider the prudence of the challenged actions. Without assessing the specific allegations at issue in *Sweda*, the Seventh Circuit stated that the Third Circuit's approach was "sound."

Lastly, the Court held that plaintiffs' prohibited transaction claims were properly dismissed because they were simply repackaged imprudence claims, and agreed with the district court that a jury trial would not be permissible for the claims asserted even if the case had proceeded.

Proskauer's Perspective

The Seventh Circuit's ruling in *Divane* appears to create a circuit split with the Third Circuit's ruling in *Sweda*. Although the Seventh Circuit purported to agree with the framework applied by the Third Circuit, the fact remains that many of the allegations in the case against the University of Pennsylvania that were allowed to proceed were nearly identical to those asserted against Northwestern and dismissed. For instance, in both cases, plaintiffs claimed that the plans entered into a bundled service arrangement with the same record-keeper; paid unreasonable administrative fees by using two record-keepers; paid fees through an asset-based arrangement; offered numerous duplicative investment options; and retained expensive, underperforming funds, with many of the funds at issue being identical. Not surprisingly, the University of Pennsylvania contended that the Seventh Circuit's opinion opened a split in the Circuits, and filed a supplemental brief in support of its petition for certiorari with the Supreme Court. The Supreme Court, however, declined to accept the case for review.

If the rationale applied by the Seventh Circuit becomes the prevailing view, it will create good opportunities for Plan sponsors and fiduciaries to prevent or defend future lawsuits challenging the administration of 401(k) and 403(b) plans. To begin with, the case recognizes that the decision to offer a particular investment alternative is less likely to be assailable when other investment alternatives are offered with comparable investment strategies. Secondly, the decision presents the opportunity for eliminating lawsuits of this type in the early stages, and thereby preventing discovery into the prudence of the decision-making process, based on the complaint's failure to plead with plausibility that the challenged practices were different from what a "hypothetical prudent fiduciary" would have chosen.

Affordable Care Act

What Employers Should Know about ACA Shared Responsibility Payments

By: Katrina McCann

A recently released redacted report from the Treasury Inspector General for Tax Administration (TIGTA) offers some helpful insights for employers who may be assessed shared responsibility payments because the IRS thinks they failed to offer adequate health coverage, as required by the Affordable Care Act (ACA).

The TIGTA report shows a wide gap between the ACA shared responsibility payment amounts the IRS initially predicted would be assessed in 2015 and 2016 (approximately $17 billion) and the actual amounts assessed once employers were given a chance to contest the proposed amounts ($749 million). The TIGTA also estimates that longer term revenue from these payments will fall very short of the amount estimated by Congress. For the 10-year period starting with fiscal year 2016, the Joint Committee on Taxation's earlier projection was that the shared responsibility payments would generate revenue of $167 billion. Using the actual assessment rates, the TIGTA's projection for this same period is approximately $8 billion.

The TIGTA's report also identified areas where IRS procedural issues or improper employer reporting resulted in an inaccurate initial calculation. In light of this news, employers should keep in mind a few key points with respect to the employer shared responsibility payments.

Monitor compliance with the ACA shared responsibility mandate.

The first step to avoiding shared responsibility payments is to ensure you're complying with the ACA shared responsibility mandate (also known as the "Pay or Play" rule).

This rule requires employers with at least 50 or more full-time employees (including full-time equivalent employees) during a calendar year ("Applicable Large Employers") to offer affordable, minimum essential health coverage to full-time employees and their dependents, and the coverage must provide minimum value. There are nuances in determining full-time status and full-time equivalence, as well as determining affordability, compliance with minimum value requirements and when the offer must be made. Accordingly, an employer reviewing operational compliance with the shared responsibility mandate may want to work closely with benefits counsel.

Generally, if the employer does not offer coverage to at least 95% of full-time employees and their dependents and even one full-time employee receives a premium tax credit, the employer is subject to a shared responsibility payment under the "A" penalty (under I.R.C. Section 4980H(a)). The A penalty can be quite steep – it is calculated as the "applicable payment amount" ($2,080 in 2014, adjusted for each year thereafter) multiplied by the total number of full-time employees.

Even if the employer offers coverage to at least 95% of its full-time employees, if a full-time employee receives a premium tax credit because coverage was not offered, was not affordable or did not provide minimum value, then the employer is subject to a shared responsibility payment under the "B" penalty (under I.R.C. Section 4980H(b)). The B penalty is calculated only based on the number of full-time employees who receive a premium tax credit, and was $3,000 in 2014, adjusted for each year thereafter.

Take care in reporting.

Applicable Large Employers must annually file information returns with the IRS on Forms 1094-C and 1095-C. Once the IRS has analyzed the Forms 1094-C and 1095-C for a tax year, it will calculate potential shared responsibility payments that may be owed and send inquiry letters to employers. Historically this process has taken a couple of years.

To reduce the likelihood of receiving an inquiry letter, an employer should carefully and accurately complete these forms. According to the TIGTA report, a majority of the adjustments to the IRS's initially proposed share responsibility payment amounts were the result of employer reporting issues. Many employers inaccurately reported on their Form 1094-C that they did not offer health insurance to employees, and when they subsequently notified the IRS of this error, the assessed amount was adjusted accordingly.

Scrutinize any shared responsibility payment notices carefully.

The IRS's initial inquiry letter will notify an employer of the proposed shared liability payment. The inquiry letter will also enclose a form for the employer to complete and return with either the payment or a statement as to why it disagrees with the proposed shared liability payment. Generally, the employer has 30 days to respond. However, in our experience, the IRS will work with employers that need more time to pull together the information necessary to respond. It is important that an employer respond to an inquiry letter in a timely way.

If you do receive an inquiry letter proposing a shared responsibility payment, it is important to review it carefully and enlist legal counsel as needed. TIGTA's report shows that in 2015 and 2015, the initial calculations included with the IRS's inquiry letters were reduced significantly based on employer responses. In our experience, we also find many of these letters to have erroneous assessments. The only way to find out if the calculated payment amount is wrong is to scrutinize the assessment carefully and compare it to the information on the reporting forms. Then, a timely response, including clear explanations and proof as to why the assessment was wrong, can help reduce or eliminate the possible shared responsibility payment obligation.

Choice of Law

Choice-of-Law Plan Provision Enforced As A Matter of Federal Common Law

By: Russell L. Hirschhorn and Kyle Hansen

The Tenth Circuit recently concluded that, as a matter of federal common law, a choice-of-law provision in a long-term disability insurance policy, which was part of the plaintiff's employer's ERISA plan, must be enforced because a "clear, uniform rule . . . is required to ensure plan administrators enjoy the predictable obligations and reduced administrative costs central to ERISA." The central issue on appeal was whether the Court's review of the decision to deny plaintiff his claim for long-term disability benefits should be governed by the highly deferential arbitrary and capricious standard of review, or reviewed de novo. The plaintiff commenced the action in Colorado, but the policy had a choice-of-law provision that required the application of Pennsylvania law. Which law to apply was of paramount importance because Colorado state law bans discretion-granting clauses while Pennsylvania does not.

The Court first determined that it need not decide whether or not ERISA preempts state laws banning discretionary clauses in insurance policies because it concluded that the Colorado law should not apply in light of the policy's choice-of-law provision. In so ruling, the Court recognized that other circuits had developed a variety of approaches to determining whether a choice-of-law provision should be enforced, all of which essentially focused on a rule of reasonableness. Without commenting on how those approaches might be applied in the instant case, the Tenth Circuit found them inappropriate because they "overlook[ed] the uniformity and efficiency objectives" central to ERISA. The Tenth Circuit further explained that a choice of law doctrine must account for the "centrality" of the plan in ERISA matters and the aims of uniformity and reduced administrative costs. Accordingly, the Court concluded that if the plan has a legitimate connection to the state whose law is chosen, ERISA's interest in efficiency and uniformity, as well as its recognition of the primacy of plan documents, compelled the conclusion that the selected law should govern as a matter of federal common law.

In the end, the Court determined that the denial of plaintiff's claim for long-term disability benefits was not arbitrary and capricious. The case is *Ellis v. Liberty Life Assurance Co. of Boston*, No. 1:15-cv-00090 (10th Cir. May 13, 2020).

Coronavirus

PBGC Announces COVID-19 Extensions for Premium Payments and Other Filing Deadlines

By: Justin Alex and Annie (Chenxiaoyang) Zhang

On April 10, 2020, the Pension Benefit Guaranty Corporation (the "PBGC") announced that deadlines for upcoming premium payments and certain other required filings due from April 1, 2020 through July 14, 2020 will be extended to July 15, 2020 as further described below.

The PBGC's announcement came a day after the Internal Revenue Service (the "IRS") issued Notice 2020-23, which extended certain deadlines, including for Form 5500 returns, to July 15, 2020 as a result of COVID-19. Under the PBGC's disaster relief policy, when the IRS announces disaster relief that includes a filing extension for Form 5500 returns, the PBGC will generally grant relief that extends certain deadlines for the same geographic area and relief period. Importantly, the IRS Notice applies nationwide and without regard to whether the applicable person is directly impacted by COVID-19, so the PBGC's relief is effectively available to all plan sponsors, administrators, and service providers.

Automatic Extensions

The PBGC's relief automatically applies to the due date for any PBGC filing, payment, or other action (including PBGC premium filings and premium payments) other than the following filings and actions on the PBGC's "Exceptions List":

- Notices of missed contributions over $1,000,000 (reported on Form 200);
- Advance reportable event notices (reported on Form 10-Advance);
- Post-event reportable event notices (reported on Form 10) for: (i) a failure to make required contributions under $1,000,000; (ii) an inability to pay benefits when due; (iii) a liquidation; (iv) a loan default; or (v) an insolvency or similar settlement; and
- Actions related to distress terminations for which the PBGC has issued a distribution notice.

Note, however, that the Coronavirus Aid, Relief, and Economic Security Act extended the deadline for all required minimum contributions to tax-qualified defined benefit plans that would have otherwise been due in the 2020 calendar year to January 1, 2021. As a result, notices to the PBGC for missed required contributions in 2020 should not be required.

In order to take advantage of the relief for premium filings, the filer must notify the PBGC as part of its Comprehensive Premium Filing, but filers are also encouraged to notify the PBGC by email to premiums@pbgc.gov referencing:

- IRS Notice 2020-23;
- Identifying information for the plan (i.e., plan name, EIN, and plan number); and
- The name and address of the affected filer.

For all other filings, the filer must notify the PBGC as soon as reasonably possible (and no later than the end of the relief period) by email to the address included in the instructions for the filing in question, and with the same information listed above.

Case-by-Case Extensions

For filings on the PBGC's "Exceptions List," the PBGC may grant relief on a case-by-case basis. Interested filers should follow the instructions for requesting a waiver or extension in the regulations or instructions for completing the filing in question or, if no such guidance is available, by contacting the PBGC as soon as reasonably possible by phone or email.

Key Considerations

The PBGC's disaster relief policy provides some welcome relief for plan sponsors, administrators, and service providers during a time when many resources are stretched thin. The PBGC premium filing and payment extensions in particular may help some plan sponsors that are facing short-term liquidity issues in light of the current business environment. Plan sponsors planning to take advantage of the relief under this policy should provide timely notice to the PBGC and should be sure that the stakeholders and resources necessary to make the delayed filings are available prior to the July 15th deadline.

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

DOL/Treasury COVID-19 Relief Includes Long Extension of Participant Deadlines and Rule of Reasonableness for Plan Administration

By: Seth Safra and Katrina McCann

On April 29, 2020, the U.S. Departments of Labor (Employee Benefits Security Administration, "EBSA") and Treasury (IRS) published a final regulation, and EBSA issued a package of guidance and relief, for employee benefit plans affected by the COVID-19 outbreak. EBSA's package includes (i) EBSA Disaster Relief Notice 2020-1, (ii) DOL COVID-19 FAQs for Participants and Beneficiaries (answering basic participant questions), and (iii) a press release. At a high level, the package includes important guidance and extensions of various deadlines. The IRS/DOL regulation is particularly noteworthy because it provides an extended period for employees to elect health coverage retroactively.

Highlights from the final regulation and the EBSA Disaster Relief Notice are described below. Both pieces of guidance state that the U.S. Department of Health and Human Services has reviewed, concurs, and will exercise its enforcement discretion to adopt a temporary policy of measured enforcement to extend certain similar timeframes.

Final Regulation Extending Certain Deadlines

Under the final regulation, all group health plans, disability, and other employee welfare plans, and all pension plans that are subject to ERISA or the Internal Revenue Code, must disregard the "Outbreak Period" for purposes of determining certain deadlines. The "Outbreak Period" runs from March 1, 2020 until 60 days after the COVID-19 National Emergency ends (or such other date as the agencies announce). If there are different Outbreak Period end dates for different parts of the country, the agencies will issue additional guidance for relevant areas.

The Outbreak Period must be disregarded for purposes of:

- The special enrollment period for enrolling in a health plan after a loss of coverage or acquiring a new dependent due to birth, marriage, adoption, or placement of adoption. Without the extension, the special enrollment period would be 30 days (or 60 days in the case of special enrollment rights under CHIP);
- The period to elect COBRA coverage. Without the extension, the election period would be 60 days from the time the election notice is provided;
- The deadline to pay COBRA premiums;
- The period to file a claim or appeal for benefits (but not the period for deciding the claim);
- The period to request external review under a health plan; and

- The deadline for a plan to provide COBRA election notices.

For example, suppose an employee terminated employment and lost health coverage on February 29, 2020. The employer would have had 14 days to provide a COBRA election notice (deadline March 14, 2020), and the employee then would have had 60 days to make an election (deadline May 13, 2020) and another 45 days to make the first premium payment (deadline June 27, 2020). With the extension, the period from March 1, 2020, until 60 days after the National Emergency ends is disregarded. Assuming that the COBRA notice would have already been provided, this means that the employee would have until 120 days after the National Emergency ends to elect COBRA—retroactive to March 1, 2020—and another 45 days after that to make the first premium payment.

EBSA Disaster Relief Notice 2020-01: Guidance and Relief for Employee Benefit Plans Due to the COVID-19 (Novel Coronavirus) Outbreak

In addition to the relief described above for plan participants and beneficiaries, EBSA Disaster Relief Notice 2020-01 includes more limited relief for plan sponsors, fiduciaries, and service providers. Rather than waive technical obligations or provide wholesale extensions of deadlines, the Notice recognizes that plan sponsors, fiduciaries, and service providers might face challenges in meeting ERISA requirements during the Outbreak Period and applies a rule of reasonableness. EBSA outlines the following guiding principles for plan sponsors, fiduciaries, and service providers who encounter problems during the Outbreak Period:

- Act reasonably, prudently, and in the interest of the covered workers and their families who rely on the plans for physical and economic well-being.
- Make reasonable accommodations to prevent the loss of benefits or undue delay in benefit payments, and attempt to minimize the possibility of individuals losing benefits because of a failure to comply with pre-established timeframes.
- EBSA's enforcement efforts will emphasize compliance assistance, including grace periods and other relief where appropriate, such as where physical disruption to a plan or service provider's principal place of business makes compliance with pre-established timeframes impossible.

The Notice also includes the following specific relief, all of which is subject to the caveat that the relief is available only to the extent it is needed:

- Delayed remittance of participant contributions and loan repayments to plans. In general, participant contributions and loan repayments must be remitted to the plan as soon as they can reasonably be segregated from the employer's general assets. Remittance may be temporarily delayed if solely attributable to the outbreak.
- Notices and disclosures. A responsible plan fiduciary will not be in violation of ERISA for failure to timely furnish a notice (including a blackout notice), disclosure, or other document required under Title I of ERISA, if:
- The responsible fiduciary acts in good faith; and
- The notice, disclosure, or document is furnished as soon as administratively practicable under the circumstances.

Good faith includes using electronic alternative means of communicating with plan participants and beneficiaries who the plan fiduciary reasonably believes have effective access, including email, text messages, and continuous access websites (for example, an intranet site).

- Temporary relaxation of ERISA plan loan and distribution verification requirements. A failure to follow plan verification procedures for loans or distributions will be excused for purposes of Title I of ERISA if:
- The failure is solely attributable to the outbreak;
- The plan administrator makes a good-faith diligent effort under the circumstances to comply with plan procedures; and
- The plan administrator makes a reasonable attempt to correct any procedural deficiencies (g., assemble missing documentation) as soon as administratively practicable.

The Notice states that this relief does not relax requirements under the Internal Revenue Code, such as spousal consent requirements (where applicable).

- Clarification with respect to the CARES Act. The Notice confirms that the expansion of loan rights under the CARES Act (described here) will not violate Title I of ERISA.
- Extension of the deadline for Form M-1 filings. The deadline for Form M-1 filings (for MEWAs and certain entities claiming exception) has been extended to align with the deadline for filing the Form 5500 (e., filings otherwise due from April 1, 2020 through July 14, 2020 are now due on July 15, 2020).

The guidance does not get into details on logistics for implementation. Plan sponsors and fiduciaries will need to grapple with issues such as:

- When and how to communicate the extensions to affected participants and beneficiaries. For example, should form notices for COBRA and special enrollment periods be updated? What format, and how much detail is appropriate, given that the extension period is fluid and will be short-lived? What should be done for people who are already in election periods and were previously informed of a deadline that has now been extended?
- Whether and how past actions can be undone. For example, if an individual's COBRA coverage was previously canceled for not paying premiums, can it be reinstated? What happens if an eligible COBRA beneficiary already obtained coverage somewhere else?

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

IRS Expands Mid-Year Change Opportunities for Health and FSA Benefits and Increases Carryover Limit

By: Seth Safra and Jennifer Rigterink

On May 12, 2020, the IRS released Notice 2020-29, which provides significant flexibility for health insurance and flexible spending account election changes during 2020, and Notice 2020-33, which increases the amount that may be carried over from one year to the next under a health flexible spending account (FSA). The guidance allows increased flexibility for employees to make or change their elections for calendar year 2020, as well as more time for employees to spend down health and dependent care FSA balances. These changes are optional and would require plan amendments.

Read below for more details about this relief, including the deadline to make plan amendments.

Mid-Year Election Changes (2020 Only)

Cafeteria plans permit employees to choose to pay for health and certain other benefits on a pre-tax basis. In general, elections must be made before the plan year starts, and mid-year changes are permitted only if there is a qualifying change in status (such as an employment change, getting married, having a baby, or moving) or a qualifying change to the benefit.

In recognition of the challenges that individuals are facing as a result of the coronavirus pandemic, some employers have permitted employees to change their health coverage mid-year—for example, to elect coverage if they had previously declined it. Absent relief, these circumstances would not necessarily be sufficient to allow a mid-year change. Notice 2020-29 makes an exception for the rest of 2020, if the plan is amended to allow the change and the change applies prospectively. Subject to those conditions, the following changes are permitted for the rest of 2020:

- **Employer-sponsored health coverage**: Employees who previously declined employer-provided health coverage may elect coverage on a prospective basis. In addition, employees who previously elected coverage may drop that coverage mid-year in conjunction with enrolling in different health coverage from the same employer or enrolling in other health coverage. An attestation is required if the employee is enrolling in outside health coverage.
- **Health and Dependent Care FSAs**: Employees may make a new election, or increase or decrease an existing election, for the rest of 2020. This relief applies for general purpose and limited purpose health FSAs, as well as for dependent care FSAs.

Employers have significant discretion in applying this relief. For example, an employer may limit the types of elections that are permitted in order to mitigate adverse selection. Also, for employers that have already loosened the election change rules, the relief applies retroactively for changes made on or after January 1, 2020.

Increase to Health FSA Carryover Limit (Permanent Change)

In general, flexible spending accounts are subject to a "use it or lose it" rule: balances must be used for eligible expenses incurred during the plan year and unused balances are subject to forfeiture. There are two exceptions to this rule for health FSAs:

1. A health FSA may cover eligible expenses that are incurred during a limited "grace period" (up to two months and 15 days after the end of the plan year).

2. A health FSA may allow employees to "carry over" up to $500 to be used for expenses incurred in the next plan year.

These exceptions are mutually exclusive: a health FSA may allow a grace period or a carryover, but not both.

Carryover Limit is Increased. Effective for plan years starting on and after January 1, 2020, Notice 2020-33 increases the $500 carryover limit for health FSAs to 20% of the annual salary reduction contribution limit. This means that the limit is increasing to $550 for 2020 (20% of the $2,750 limit on salary reduction contributions). Future adjustments will be in $10 increments. If permitted by the employer's plan, employees may change their elections for the remainder of 2020 to account for this increase.

Special Relief for Non-Calendar Year Plans and Plans With Grace Periods (2020 Only)

Notice 2020-29 also includes special relief for plans under which the deadline to incur expenses ends during 2020 (before December 31st)—whether due to a grace period that ends during 2020 or a non-calendar plan year that ends during 2020. Under this relief, a plan may extend the deadline to incur expenses to December 31, 2020. For example, if the grace period for incurring claims under a health FSA ended on March 15, 2020, the plan may be amended to allow remaining balances to be used for eligible health expenses incurred later in calendar year 2020. Similarly, if the plan year for a flexible spending account (health or dependent care) ends on June 30, 2020, the plan may be amended to allow the FSAs to be used for eligible expenses incurred later in calendar year 2020.

Again, these changes are optional, and they are not all or nothing. Employers may choose which relief to make available (if any).

* * *

Plan sponsors that wish to make changes for 2020 should communicate the changes to affected employees in time to be useful and must adopt conforming plan amendments no later than December 31, 2021.

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

One Problem Solved: Notice 2020-42 Provides Temporary Relief for Witnessing Spousal Consents

By: Robert Projansky and Elizabeth Down

This afternoon, the Treasury Department issued Notice 2020-42, ending the uncertainty surrounding spousal consents to retirement plan distributions and loans in the socially distanced COVID-19 world.

As plan administrators know, when spousal consent is required for a plan distribution or loan, the law requires that the consent be witnessed by a notary public or plan representative. Although the applicable Treasury Regulations allow the actual notarization or acknowledgment of the witnessing to be *signed* electronically consistent with ESIGN, the Regulations still require that the notary or plan representative *witness* the spouse's signature in the physical presence of the signer.

In light of the stay-at-home and social distancing orders that have swept the country during the COVID-19 outbreak, this physical presence requirement has been a huge roadblock to plan administration of loans and distributions because many participants and their spouses simply did not have physical access to a notary or plan representative or were concerned about interacting with people outside their homes. Many states have relaxed their notarization rules and allowed for remote electronic notarization, but this was of limited utility for retirement plan purposes because of the federal physical presence requirement for spousal consents.

That all changed this morning with IRS Notice 2020-42, which finally provides temporary relief from the physical presence requirement for calendar year 2020 (retroactive to January 1).

Specifically, the physical presence of a notary or witness for spousal consent is not required during this period if certain rules are satisfied. In the case of the notary, this will apply to any consent witnessed by a notary of a state that permits remote electronic notarization. The execution by the notary would have to be through a live audio-video conference meeting the state's requirements for remote notarization, as well as the normal regulatory requirements for electronic signature.

Where remote notarization is not available or inconvenient, the use of a plan representative to witness spousal consent is a helpful alternative (assuming the plan permits it or is amended to do so). To satisfy Notice 2020-24, this method must incorporate a live audio-video conference that meets the following requirements (which, unsurprisingly, are not dissimilar to many states' remote notarization rules):

- The spouse must present valid photo ID during the conference (not before or after);
- The conference must allow for direct interaction between the spouse and the plan representative (meaning, for example, that the representative cannot watch a pre-recorded video of the person signing);
- On the day the document is signed, the spouse must send a legible copy of the signed document electronically or by fax directly to the plan representative;
- After receiving the signed document, the plan representative must acknowledge that the signature has been witnessed by the plan representative in accordance with these requirements; and
- The plan representative must send the signed document and acknowledgement back to the spouse under a system that satisfies certain regulatory requirements for electronic notice (i.e., the recipient has to have the effective ability to access the electronic medium used, the recipient must be told of the right to request a paper copy at no charge and such a paper copy must be provided on request).

This is welcome relief for many retirement plan administrators who were unsure how to act in the face of a requirement that became entirely impractical due to circumstances that no one could have foreseen. Those administrators that adopted alternative procedures in advance of this guidance should consider comparing their procedures to those set forth in Notice 2020-24 and determining whether any prospective or retrospective action is appropriate.

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

New IRS Guidance Answers Pressing CARES Act Questions for Retirement Plans

By: Seth Safra and Randall Bunnell

On May 4th, the IRS released a set of FAQs focused on the special coronavirus-related distribution ("CRD") and plan loan options under the CARES Act (described here).

To recap, the CARES Act allows expanded distribution options and favorable tax treatment for up to $100,000 of CRDs from eligible retirement plans (including section 401(k) and 403(b) plans, and IRAs), as well as an opportunity to repay the CRDs. The Act also increases the limits for plan loans and allows certain loan repayments to be deferred by up to an additional year. These opportunities are available only to individuals who satisfy specified conditions related to COVID-19, and the expanded distribution and loan opportunities sunset at the end of 2020.

The FAQs offer helpful guidance for sponsors of retirement plans who are considering adding special distribution and/or loan options for participants affected by COVID-19. The following are some of the highlights:

- **When in doubt, follow the KETRA playbook.** The FAQs say the IRS anticipates releasing more comprehensive guidance "in the near future." The IRS anticipates the guidance will apply the principles of its guidance under the Katrina Emergency Tax Relief Act of 2005 ("KETRA"), which provided loan and distribution relief that was very similar to the relief offered under the CARES Act. The KETRA guidance is set forth in IRS Notice 2005-92.
- **Participants may self-certify that they are eligible, but there is a price to pay for misrepresentations.** The FAQs reinforce that a plan administrator may rely on a participant's self-certification that he or she satisfies the conditions for a CARES Act loan or distribution. However, the favorable tax treatment for CRDs (that is, the ability to recognize income over three years and avoid the 10% additional tax on early distributions) is conditioned on the individual actually meeting the conditions. In other words, a misrepresentation by a participant should not cause a plan to be disqualified (assuming the plan administrator does not know about the

misrepresentation), but the individual who makes misrepresentations can be subject to tax penalties.

- **CRDs and CARES Act Loans are *optional*.** The FAQs confirm that a plan sponsor may choose whether, and to what extent, to offer CRDs and/or loan relief under the CARES Act. For example, a plan sponsor could amend its plan to allow for CRDs and the suspension of loan repayments, but choose not to increase plan loan limits. Similarly, a plan could be amended to allow CRDs from some contribution sources but not others or to impose a cap on CRDs that is lower than the $100,000 permitted by the CARES Act. Regardless of whether a plan is amended to allow CRDs, an individual who satisfies the conditions for a CRD may claim the favorable tax treatment for any distribution that satisfies the CRD requirements and is (or was) received during 2020 (before December 31st).

- **The IRS "anticipates" that plans will accept repayment of CRDs, but acceptance of repayments is not necessarily required.** The CARES Act allows participants to repay CRDs to an eligible retirement plan or IRA, and specifies that repayments will be treated as rollover contributions. The FAQs clarify that if a plan does not accept rollover contributions, the plan is not required to accept repayments of CRDs. However, the FAQs do not say whether plans that accept rollover distributions may choose not to accept CRD repayments.

- **Additional restrictions apply for pension plans.** The FAQs state that the CARES Act relief for in-service withdrawals is limited to section 401(k), 403(b), and governmental 457(b) plans. The CARES Act does not change the rules for when a distribution from a defined benefit or money purchase plan is permitted. In general, this means that distributions from a defined benefit or money purchase plan would not be permitted before age 59½, severance from employment, or disability. In addition, the FAQs clarify that spousal consent is required for a CRD if required by the plan.

- **More to come on how to report CRDs.** The FAQs state that the payment of a CRD must be reported by the plan on a Form 1099-R, even if the participant repays the CRD in the same year. The FAQs do not specify ***how*** to report the CRD; the IRS expects to issue guidance on that later in 2020. In the meantime, the FAQs refer generally to section 3 of the KETRA guidance.

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

IRS Extends Participant Eligibility for Distributions and Loans Under the CARES Act

By: Malerie Bulot and Seth Safra

In Notice 2020-50, the IRS expanded eligibility for CARES Act distributions and loans, and provided additional guidance. To recap (as described here), the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") added three types of distribution and loan flexibility under eligible retirement plans for certain "qualified individuals": (1) "coronavirus-related distributions" ("CRDs") up to $100,000 that are eligible for favorable tax treatment and generally may be repaid to the plan or an IRA within 3 years, (2) suspension for up to one year of loan repayments otherwise due from March 27, 2020, through December 31, 2020, and (3) increased loan limits. In May FAQs, the IRS made clear that these provisions are optional.

The CRDs and expanded loan opportunities are available only for "qualified individuals" who are diagnosed, or have a spouse or dependent who is diagnosed, with SARS-CoV-2 or COVID-19, or who otherwise experience "adverse financial consequences" due to various coronavirus-related circumstances. The qualifying circumstances under the CARES Act statute included things like being furloughed or having hours reduced but did not include a reduction of pay. Notice 2020-50 expands the list of qualifying circumstances to include the following:

- Having a reduction in pay or self-employment income;
- Having a job offer rescinded or a start date delayed;
- Having a spouse or household member who experiences the consequences described above, or who is quarantined, furloughed or laid off, has hours reduced, or is unable to work due to lack of childcare caused by COVID-19; or
- Experiencing a closing or reduction of hours of a business owned by the participant's spouse or a household member.

In addition to expanding eligibility for CRDs and the CARES Act loan relief, the Notice includes the following guidance:

- **Elaborates on the ability to designate distributions as CRDs even if the plan does not have CRD provisions.** Qualified individuals may designate as

CRDs any distributions of up to $100,000 from "eligible retirement plans" that are made on or after January 1, 2020, and before December 31, 2020—even if the plan has not adopted CRDs. This includes, for example, periodic payments previously made for minimum required distributions as well as payments received as a beneficiary and offsets to repay qualifying plan loans. However, corrective distributions, dividends on employer securities, and certain similar distributions are not eligible. Also, as discussed here, money purchase and defined benefit pension plans are not "eligible retirement plans;" so distributions from those plans are not eligible for CRD treatment.

- **Not all CRDs may be repaid.** A CRD may be repaid to the plan or an IRA only if it is eligible for tax-free rollover treatment. Accordingly, CRDs paid to a non-spouse beneficiary cannot be repaid.

- **Details the individual tax consequences of taking or repaying a CRD.** The guidance describes logistics for including CRDs in income ratably over three years and for repaying the CRD. Because income inclusion for CRDs is delayed, it is possible to repay CRDs before they are ever subject to income tax. But if a qualified individual repays a CRD after having filed his or her tax return, the individual would have to restate his or her tax return to get full tax-free rollover treatment.

- **Elaborates on withholding and reporting for CRDs.** The Notice states that CRDs are not subject to the rules for eligible rollover distributions. This means that the plan does not have to offer a rollover for a CRD, and CRDs are subject only to voluntary withholding. The Notice gives flexibility for reporting CRDs on Form 1099-R: they can be reported with distribution code 2 (to note an exception from the 10% additional tax on early distributions) or code 1 (early distribution, no known exception). Regardless of how the plan reports the CRD, it is the recipient's responsibility to manage the $100,000 limit on an aggregate basis (counting distributions from multiple plans, if applicable).

- **Provides self-certification language for an individual to claim eligibility for a CRD or loan.** The Notice reiterates that plan administrators may rely on individual self-certification of eligibility for a CRD or CARES Act loan, unless the administrator "actual knowledge" to the contrary. The Notice includes language that can be used for this self-certification.

- **Provides a safe harbor for reamortizing loans after a suspension.** For all plans, loan repayments must resume by January 2021. The Notice recognizes that there can be more than one reasonable way to reamortize the loan when payments restart. The safe harbor allows substantially equal payments over the remainder of the original loan term plus up to one year.

- **Coordination with non-qualified deferrals.** The notice allows a nonqualified deferred compensation plan to treat a CRD like a hardship withdrawal for purposes of canceling deferral elections mid-year.

* * *

Guidance on the CARES Act and other COVID-19 matters is evolving constantly. Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

Department of Labor

DOL Information Letter Outlines Fiduciary Considerations for Including Private Equity Allocations in Defined Contribution Plan Investments

By: Ira G. Bogner, Seth Safra, Adam Scoll, Pamela Onufer and Kaitlin Hulbert

On June 3, 2020, the Department of Labor (the "DOL") published an Information Letter confirming that investment options under a defined contribution plan (*e.g.*, a 401(k) or 403(b) plan) may include a limited allocation to private equity. Notably, the Letter does not discuss direct investment in private equity funds (for example, by adding a PE fund to the plan's investment lineup). Rather, the Letter discusses including private equity as a small allocation within a diversified designated investment option such as a balanced fund or a target date fund (a footnote in the Letter suggests no more than 15%); and the Letter notes that direct investment in private equity would "present distinct legal and operational issues."

The Letter emphasizes that selection and monitoring of an investment option with private equity is subject to the same fiduciary considerations as other investments (including the duties to be prudent and loyal, and the duty to avoid prohibited transactions). At a high level, this includes evaluating whether the potential upside from the investment justifies the added risk, fees, complexity, and valuation and liquidity issues. The Letter lists the following specific considerations:

- Whether the investment option is sufficiently diversified to mitigate risk over a multi-year period;

- ???Whether the investment option is overseen by plan fiduciaries (using third-party investment experts as necessary) or managed by investment professionals with the appropriate private equity-related expertise;
- ???Whether the allocation within the investment option to private equity is sufficiently limited to address cost, complexity, disclosure, liquidity and valuation issues unique to the asset class (again, a footnote suggests no more than 15%);
- ???Whether the investment option is appropriate for the participant profile (including, for example, participant ages, normal retirement age, anticipated employee turnover, and contribution and withdrawal patterns) and aligns with the plan's characteristics and needs of plan participants;
- ???Whether the plan fiduciary has the skills, knowledge and experience to make the required determinations regarding adding and monitoring such allocation, or whether it needs to seek expert guidance; and
- ???Whether participants will be furnished adequate information regarding the character and risks of such an allocation (in particular, for plan fiduciaries relying on the protection provided under ERISA Section 404(c)).

Although the Letter includes detail that is unique to the private equity asset class, it does not change the law or general fiduciary responsibilities with respect to defined contribution plans. In fact, some defined contribution plans have had private equity and other alternative asset allocations within their investment options for years; and challenges to the prudence of those investments are actively being litigated. Also, the Letter references, and does not resolve, additional issues that might arise under ERISA's prohibited transaction rules, as well as under securities, banking, tax, and other laws.

* * *

The considerations for investment options under defined contribution plans continue to be complex, and depend on the needs of the particular plan and the participant base. Proskauer's cross-disciplinary employee benefits and asset management teams are focused on supporting and addressing these considerations in a practical way.

Department of Labor Finalizes New Safe Harbor for Electronic Delivery of Retirement Plan Disclosures

By: Steven Weinstein, Jennifer Rigterink and Annie (Chenxiaoyang) Zhang

On May 21, 2020, the U.S. Department of Labor (the "DOL") finalized its proposed regulation expanding electronic delivery for retirement plan disclosures. On balance, the final regulation is generally consistent with the proposed regulation, although there are a number of key differences, including the addition of a new "direct email" delivery option not included in the proposed regulation.

The final regulation will likely provide welcome relief for plan sponsors and administrators frustrated by the limitations of the current DOL safe harbor for employees with work-related computer access ("wired at work") or who have consented to electronic delivery ("consumer consent"). However, there are detailed content, notice, and timing requirements in the new electronic delivery safe harbor that require careful review before implementation.

Threshold Requirements For Using New Electronic Delivery Safe Harbor

To take advantage of the new electronic delivery safe harbor, there are three threshold rules:

- **Applies Only to Retirement Plan Disclosures**. The safe harbor applies only to the delivery of certain "covered" documents, which generally include any document or information that must be furnished by a retirement plan pursuant to Title I of ERISA, except for any document that must be furnished only upon request. To the disappointment of many commenters on the proposed regulation, the new safe harbor does not apply to health or other welfare benefit plan disclosures.
- **Covered Individual Must Have Provided Electronic Address**. To provide covered documents to an individual under the new safe harbor, the individual entitled to the documents must have provided an "electronic address," such as an email address or internet-enabled smartphone number, to the employer, plan sponsor, or plan administrator. Employer-assigned electronic addresses may be treated as provided by the individual, as long as the electronic address is not assigned for the sole purpose of receiving retirement plan disclosures (*e.*, it must have a separate employment-related purpose).
- **Must Distribute Initial Notice on Paper**. Prior to reliance on the safe harbor, a plan administrator must distribute an initial notice on paper to covered individuals, advising them that disclosures will be electronically provided unless they affirmatively opt out. The requirement to provide this notice on paper is absolute, even for individuals who are already "wired at work" or previously provided consumer consent. The initial notice must identify the individual's electronic address and meet other detailed content requirements.

Two Ways to Deliver: "Notice-and-Access" and "Direct Email"

Provided the threshold requirements for relying on the electronic delivery safe harbor are met, plan sponsors and administrators have two options for delivering covered documents electronically:

- **"Notice-and-Access" Option**. This option requires posting covered documents on electronic media, such as a website or mobile application, and notifying covered individuals that the document is posted by sending them a separate "Notice of Internet Availability" (the "NOIA"). The NOIA must comply with detailed content requirements, including an identification of the covered document, the electronic address (or hyperlink to the address) where the individual can access the document, and several required statements that advise individuals of their right to opt out of electronic delivery and to receive free paper copies.
- **"Direct Email" Option**. In lieu of using the "notice-and-access" option described above, covered documents may be sent via "direct email" to covered individuals who have provided email addresses or have employer-assigned email addresses. (This method cannot be used if the only electronic address for an individual is his or her smartphone number.) A covered document may be sent in the body of an email or as an attachment. The email message itself is subject to specific content requirements.

Additional Requirements For Using New Electronic Delivery Safe Harbor

Reliance on the new electronic delivery safe harbor is subject to detailed content, notice, and timing requirements, some of which are noted below.

- **Global Opt-Out of Electronic Delivery**. Covered individuals must be permitted to globally opt out of electronic delivery of all covered documents and receive paper copies at no cost. This marks a change from the proposed regulation, which allowed individuals to pick and choose which documents they wanted to receive on paper. For administrative ease, the regulatory preamble indicates that plan administrators may continue to deliver electronic notices and disclosures to individuals who have opted out, as long as paper copies are also provided.
- **Consolidated NOIA**. As noted above, using the "notice-and-access" option requires providing a NOIA to covered individuals each time a covered document is posted—which could lead to "NOIA fatigue." However, the final regulation permits using a single consolidated NOIA for certain documents in lieu of sending a separate NOIA each time a document is posted. A consolidated NOIA is limited to covering the summary plan description and certain annual disclosures (such as an

annual funding notice, SAR, and QDIA notice), as well as other documents authorized by the DOL and the Department of Treasury. Notably, quarterly pension benefit statements are not eligible for the consolidated NOIA, meaning a separate NOIA for each statement is needed. The consolidated NOIA must be provided at least once every plan year (but not less than once every 14 months).

- **Does Not Replace "Wired at Work" or Consumer Consent Safe Harbor; 18-Month Transition Period for Prior Interpretive Guidance**. The new safe harbor is an additional option for electronic disclosure, and does not replace the prior DOL "wired at work" or consumer consent safe harbor for electronic delivery. In addition to the prior DOL safe harbor, the DOL previously issued interpretive guidance permitting electronic delivery for specific documents (pension benefit statements, QDIA notices, and participant-level investment disclosures), provided certain requirements were met. In the interest of establishing a "uniform" electronic delivery system, the ability to rely on the prior interpretive guidance is eliminated. However, recognizing that some time is needed to adjust to the new standard, plan administrators may rely on the interpretive guidance for 18 months following the effective date of the final regulation (July 26, 2020).

- **Bright-Line Retention Rule for Covered Documents Posted on Electronic Media**. If the "notice-and-access" option is used, the final regulation requires that covered documents remain posted and available until superseded by a subsequent version. However, the final regulation provides a bright-line retention rule of at least one year for documents that are not subject to supersession (such as a blackout notice). This rule does not alter the general retention, recordkeeping, and reporting requirements that otherwise apply under ERISA.

- **Plan Administrator Must Have System For Identifying Bounce Backs**. The electronic delivery system must be designed to alert the plan administrator of a covered individual's invalid or inoperable electronic address (a bounce back). If a bounce back is received, the plan administrator must promptly take reasonable steps to cure the problem, by sending the NOIA or email to a secondary electronic address on file, obtaining a new valid and operable electronic address, or treating the covered individual as having globally opted out of electronic disclosures.

- **Maintenance of "Reasonable" Opt-Out Procedures**. The final regulation requires the plan administrator to maintain "reasonable procedures" permitting covered individuals to opt out of electronic delivery and to request paper copies of any document furnished electronically. Presumably, limiting election changes and requests to certain time intervals (*g.*, changes to opt-out elections once per quarter) would be "reasonable" under the rule, but further guidance confirming the reasonableness standard in this context would be helpful.

- **Steps to Ensure Continued Viability of Electronic Address After Severance from Employment**. For covered individuals with employer-assigned electronic addresses, the plan administrator must take "measures reasonably calculated" to ensure the accuracy and availability of the covered individual's electronic address or to obtain a new address that enables receipt of covered documents after severance from employment. However, if the individual already receives covered documents via a personal electronic address (*g.*, a personal email or smartphone number), the plan administrator is not required to take any additional steps to ensure the continued viability of the electronic address after termination of employment, subject to the otherwise applicable rules in the safe harbor (*e.g.*, maintenance of a system to identify bounce backs).
- **Transition Rule For Electronic Addresses Already On File**. The final regulation requires that the individual provide the electronic address to the plan sponsor or administrator. However, for plan administrators transitioning to the new safe harbor, electronic addresses already in the possession of the plan sponsor or plan administrator may be used without verifying the address was provided "by" the individual, as long as such reliance is in good faith and otherwise complies with the rules of the new safe harbor.

* * *

Plan sponsors and administrators may rely on the new electronic delivery safe harbor immediately. However, there are several practical matters that should be considered before implementing the new safe harbor, such as coordinating with vendors and adjusting existing service agreements that apply to the delivery of retirement plan disclosures. In addition, plan sponsors and administrators that currently rely on the prior DOL interpretive guidance for electronic delivery of certain documents should consider how best to adjust those delivery methods before the end of the 18-month transition period.

Department of Labor Proposal Would Curtail ESG Investing

By: Ira G. Bogner, Russell L. Hirschhorn, Seth Safra, Steven Weinstein, Adam Scoll and Kyle Hansen

On June 23, 2020, the U.S. Department of Labor (the "DOL") issued a proposed rule (which was published in the Federal Register on June 30, 2020) that would amend its "investment duties" regulation set forth at 29 C.F.R. § 2550.404a-1. The DOL states that the proposed rule is intended to "eliminate confusion" and limit when and how ERISA plan fiduciaries may (i) consider non-pecuniary factors, such as environmental, social and corporate governance ("ESG") factors (also referred to as "socially responsible investments" or "economically targeted investments"), when making plan investment decisions for a defined benefit plan, or (ii) offer an ESG-themed investment option under an individual account defined contribution plan (e.g., a 401(k) plan). In particular, the proposed rule would:

- codify what the DOL describes as its longstanding position that ERISA plan fiduciaries of both defined benefit and defined contribution plans must make investment decisions based solely on the risk-adjusted value to plan participants and beneficiaries and may not subordinate the interests of the plan to unrelated goals or objectives;
- provide specifically that ERISA's exclusive purpose rule and duty of loyalty prohibit fiduciaries from considering any non-pecuniary factors over the financial and retirement income interests of plan participants and beneficiaries;
- provide that ESG factors can be pecuniary factors only if they present economic risks or opportunities that qualified investment professionals would treat as material economic considerations under generally accepted investment theories;
- require ERISA plan fiduciaries to consider how an investment or investment course of action compares to available alternatives;
- require specific documentation in the "rare circumstances" where, after appropriate investment analysis, fiduciaries consider ESG factors as a "tie-breaker" in choosing between economically "indistinguishable" investments; and
- without limiting ERISA's general rules, confirm that an ESG fund may be added to a 401(k)-type plan only if (i) the fund is well managed and adequately diversified, (ii) the fund is selected and monitored through a prudent process, based only on objective risk-return criteria, (iii) the relevant factors are documented, and (iv) the fund is not used as the plan's qualified default investment alternative (or a component of the QDIA).

In its commentary, the DOL noted the confusion that persists for ERISA plan fiduciaries in regards to its ESG-investing rules, which the DOL acknowledged may be a result of varied statements it has made over the years in past guidance. In short, the proposed rule would codify the DOL's view that the sole focus of ERISA plan fiduciaries must be the financial returns and risk to participants and beneficiaries. ERISA plan fiduciaries must not sacrifice investment returns, take on additional investment risk, or pay higher fees to promote non-pecuniary benefits or goals.

The DOL invited comments from the public on all facets of the proposal (which are due by July 30, 2020, 30 days after the date of publication in the Federal Register). If finalized, these rules would become effective 60 days after publication of the final rule.

Fiduciary Breach

Fifth Circuit Upholds Dismissal of Diversification and Prudence Claims Targeting A Single Stock Fund in a 401(k) Plan

By: Benjamin Flaxenburg, Russell L. Hirschhorn and Seth Safra

The Fifth Circuit in *Schweitzer v. Inv. Comm. of Phillips 66 Sav. Plan* dismissed claims against 401(k) plan fiduciaries related to allowing plan participants to hold a single stock that was not an employer security as a plan investment alternative. No. 18-cv-20379, 2020 WL 2611542 (5th Cir. May 22, 2020). The Court held that: (i) 401(k) plan fiduciaries had a duty to ensure that the plan's investment line-up was diversified, but no duty to ensure that participants actually diversified their portfolios; (ii) the Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014), effectively foreclosed claims that the plan fiduciaries should have taken action on the basis of public information that suggested risk from holding the stock; and (iii) ERISA does not prohibit an individual account plan, like a 401(k) plan, from offering a single-stock fund.

As discussed below, the Court's decision offers meaningful guidance to fiduciaries of participant-directed plans and, more specifically, to those evaluating what to do with a company stock fund after a spinoff or divestiture.

Background

ConocoPhillips maintained a 401(k) plan with two employer stock funds that invested in ConocoPhillips stock. ConocoPhillips spun off certain operations to Phillips 66, which was not affiliated with ConocoPhillips. The spinoff resulted in the transfer of over 10,000 ConocoPhillips employees to Phillips 66, and their 401(k) accounts were transferred to a separate plan sponsored by Phillips 66.

Many of the transferred employees had invested in the ConocoPhillips stock funds. Those investments transferred in-kind to the Phillips 66 plan. As a result, the Phillips 66 Plan held two funds with a single stock that was not an employer security. The Phillips 66 plan's fiduciaries closed the funds to new investments, and participants were allowed to sell at any time, but those who did not want to sell were allowed to hold their investments in the funds. During the five-year period that followed the spinoff, ConocoPhillips's share price increased significantly and then decreased just as significantly.

Participants in the Phillips 66 Plan filed a putative class action complaint alleging two ERISA breach of fiduciary duty claims: breach of the duty of diversification by offering the ConocoPhillips stock funds; and breach of the duty of prudence for failing to remove the ConocoPhillips stock funds. The participants pointed to the inherent risk of investing in a single stock and publicly available "red flags" that purportedly signaled additional risk.

The district court dismissed the complaint for failure to state a claim. The district court first found that the diversification claim failed because participants could no longer invest in the ConocoPhillips stock funds and participants could remove their assets from the funds at any time. The district court concluded that the claim was really an issue of prudence and whether the plan fiduciaries should have forced participants to divest their holdings from the funds. The district court then evaluated the participants' breach of the duty of prudence claim and concluded that it was foreclosed by the Supreme Court's ruling in *Dudenhoeffer.*

The Fifth Circuit's Opinion

The Fifth Circuit affirmed the district court's dismissal of all claims. To begin with, the Court concluded that the diversification claim failed because the complaint lacked any allegation that the fiduciaries failed to offer a diverse menu of investment options or otherwise warn the participants of the risk of assembling a non-diversified portfolio. In so ruling, the Court rejected the participants' reliance on authority addressing diversification requirements for defined benefit plans. The court explained that, for a defined contribution plan, a fiduciary's responsibility is to create a diverse menu of available investment options. Individual options on the menu do not necessarily have to be diverse, and allocation of assets among the available options is the responsibility of each participant.

The Court next turned to the participants' claim that the fiduciaries breached the duty of prudence by allowing participants to hold their investments in the ConocoPhillips stock funds after the spinoff. First, the Court concluded that the Supreme Court's decision in *Dudenhoeffer* precluded plaintiffs' claim that the plan fiduciaries should have known from publicly available information that ConocoPhillips' share price did not adequately reflect the stock's risk.

Nevertheless, the Court noted that, under some circumstances, it could be imprudent to keep a single-stock fund on the investment menu. The Court determined that *Dudenhoeffer* did not control here because this was not a claim about whether the plan fiduciaries should have taken action based on publicly available information and did not involve employer securities. The Court concluded that the fiduciaries were not imprudent because they had closed the ConocoPhillips stock funds to new investments and adequately warned participants of the risks of not diversifying in the summary plan description.

Proskauer's Perspective

The Fifth Circuit's ruling approves a common approach for handling company stock funds after a spinoff or similar divestiture. Nevertheless, plan fiduciaries should continue to monitor all investment options, and to keep investment disclosures up to date, to ensure that participants have the information necessary to make sound investment decisions.

Mental Health Parity

Limitation To Restorative Speech Therapy Does Not Violate MHPAEA

By: Kyle Hansen

A federal district court in Massachusetts concluded that a health insurance plan did not violate the Mental Health Parity and Addiction Equity Act by denying coverage for speech therapy to a plan beneficiary who required speech therapy in connection with autism spectrum disorder. The plan denied coverage because the speech therapy sought was for non-restorative speech therapy, and the plan only covered restorative speech therapy. The district court concluded that the exclusion on its face did not purport to address only mental health benefits and, in fact, the exclusion evinced no differentiation between mental health benefits and medical/surgical benefits given that the exclusion limited coverage for all speech therapy that is restorative, i.e., intended to regain a level of speech that was previously intact. The case is *N.R. v. Raytheon Co.*, No. 20-cv-10153 (D. Mass. June 9, 2020).

Retiree Health Care Benefits

Third Circuit Rejects Claim for Lifetime Medical Benefits

By: James W. Barnett

Several retired employees of Dominion Energy Transmission, Inc. sued their former employer alleging that they were entitled to lifetime healthcare benefits, and the unilateral changes made by Dominion to their post-retirement medical benefits violated ERISA. The Third Circuit concluded that the retirees failed to state a claim. Applying ordinary principles of contract interpretation, the Court concluded that the CBA did not "clearly and expressly" vest the retirees with lifetime benefits. In so ruling, the Court rejected the retirees' argument that because the Plan required union consent before altering medical benefits and also did not include a general durational clause, it could be inferred that "the parties clearly expressed their intent to vest post-retirement medical benefits." The "absence of a termination clause combined with a consent clause does not clearly and expressly vest retirees" with lifetime benefits, said the Third Circuit. The case is *Blankenship v. Dominion Energy Transmission, Inc.*, No. 19-3374, 2020 WL 3397740 (3d Cir. 2020).

Standing

U.S. Supreme Court Holds ERISA Defined Benefit Plan Participants Without Monetary Losses Lack Article III Standing to Assert Breach of Fiduciary Duty Claims

By: Russell L. Hirschhorn and Tulio Chirinos

Earlier today, the U.S. Supreme Court affirmed a decision by the Eighth Circuit holding that ERISA plan participants lack Article III standing to sue for breach of fiduciary duty to recover investment losses in a defined benefit fund that was not underfunded. The Court concluded that the participants lacked a concrete stake in the dispute because they would receive the full value of their promised benefits regardless of the outcome. In so holding, the Court rejected all four of plaintiffs' alternative standing arguments, finding that: (i) in the defined benefit plan context, the trust law principle that an injury to the plan is an injury to the participant is inapplicable because participants' benefits are fixed and do not depend on the value of the plan; (ii) asserting a claim on behalf of an ERISA plan under Section 502(a) does not alleviate the requirement under Article III that the named plaintiff suffer an injury-in-fact; (iii) satisfying statutory standing (i.e., being a person authorized to sue to vindicate the statute) does not mean that a plaintiff "automatically" satisfies Article III's injury-in-fact requirement; and (iv) the question of whether there are independent means to regulate fiduciary conduct is irrelevant to the Article III standing issue and, in any event, defined benefit plans are regulated and monitored in multiple ways, including by the Department of Labor.

Justice Thomas concurred in the Court's opinion but wrote separately to again set forth his objection to the Court's practice of using the common law of trusts as a "starting point" for interpreting ERISA instead of the language of ERISA itself. Justice Sotomayor authored a lengthy dissent arguing that plan participants have standing to sue for violations of ERISA fiduciary duties regardless of whether the plan's losses reduced participant benefits.

The case is *Thole v. U.S. Bank, Nat'l Ass'n*, 2020 WL 2814294 (U.S. June 1, 2020).

* This article was originally published in Lexis Practice Advisor.® Reproduction of this material, in any form, is specifically prohibited without written consent from LexisNexis.

Related Professionals

???Russell L. Hirschhorn
Partner