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IRS Guidance on COBRA Premium Assistance — What We Know Now

SARAH KANTER

JULY 2021

After the passage of the American Rescue Plan Act of 2021 (ARP) and release of DOL model notices and FAQs on April 7, 2021, employers and other plan sponsors were still left with many open questions regarding the implementation of COBRA premium assistance. The IRS provided clarity to many of these issues with Notice 2021-31 released on May 18, 2021. This article provides a summary of Notice 2021-31. For an in-depth overview of the ARP's provisions regarding COBRA premium assistance, see Elizabeth Loh's article from March 18, 2021.

The ARP provides for COBRA premium assistance for certain COBRA Qualified Beneficiaries ("Assistance Eligible Individuals") during the period from April 1 through September 30, 2021. To qualify for COBRA premium assistance under the ARP, an individual must:

1. be a Qualified Beneficiary under normal COBRA rules (i.e., the covered employee, the covered employee's spouse, and the covered employee's dependent children who were covered under the group health plan immediately before the qualifying event);

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2. have lost coverage as a result of a qualifying event that was: (A) the reduction of hours of a covered employee's employment or (B) the involuntary termination of a covered employee's employment (other than by reason of an employee's gross misconduct);

3. be eligible for COBRA coverage for some or all of the period beginning on April 1, 2021 through September 30, 2021.

IRS guidance regarding each of these requirements is explained in greater detail below.

What Coverage Is Eligible for Premium Assistance?

Notice 2021-31 clarifies that premium assistance is available for COBRA coverage offered under the following in addition to plans providing major medical and prescription drug coverage:

- a vision-only or dental-only plan;
- a health reimbursement arrangement (HRA);
- an HRA integrated with individual health insurance coverage.

Premium assistance is not available for a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), as it is not considered a group health plan subject to the continuation requirements of COBRA.

When Does Premium Assistance End?

COBRA premium assistance is available to an Assistance Eligible Individual until the earliest of: (1) the first date the Assistance Eligible Individual becomes eligible for other group health plan coverage or Medicare coverage; (2) the date the individual ceases to be eligible for COBRA coverage; or (3) the end of the last period of coverage beginning on or before September 30, 2021. If subsidized COBRA coverage ends with the period of coverage that includes September 30, 2021, the COBRA coverage will automatically continue, and the individual will owe a COBRA premium for subsequent COBRA coverage. Note: The payment of COBRA premiums is subject to the extension under EBSA Disaster Relief Notice 2021-01.

See below for a discussion of what constitutes "eligibility" for another group health plan or Medicare.

What Is a "Reduction in Hours"?

Notice 2021-31 clarifies that the following events constitute a "reduction in hours" under ARP for the purposes of premium assistance:

- *Furloughs* — A furlough is defined in the guidance as a temporary loss of employment or complete reduction in hours with a reasonable expectation of return to employment or resumption of hours (for example, due to an expected business recovery of the employer) such that the employer and the employee intend to maintain the employment relationship.

- *Strike or Lockout* — A reduction in hours includes a work stoppage that is the result of a lawful strike initiated by the employees or union, or a lockout initiated by the employer.

What Is an "Involuntary Termination of Employment"?

Notice 2021-31 states the following with regard to the circumstances that constitute an involuntary termination of employment (pertinent excerpts):

> "A severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services....In addition, an employee initiated termination of employment constitutes an involuntary termination of employment for purposes of COBRA premium assistance if the termination of employment constitutes a termination for good reason due to employer action that results in a material negative change in the employment relationship for the employee analogous to a constructive discharge.... The determination of whether a termination is involuntary is based on the facts and circumstances."

Notice 2021-31 further clarifies that an involuntary termination *includes* the following situations:

- An employer's actions to end an individual's employment while the individual is absent from work due to illness or disability, if that action would otherwise constitute an involuntary termination. Absence from work due to illness or disability on its own would not constitute an involuntary termination, but may constitute a reduction in hours that may qualify the individual for COBRA premium assistance.
- Termination of employment for cause (except for gross misconduct, as that would not constitute a COBRA qualifying event).
- Resignation due to a material change in the geographic location of employment for the employee.
- A termination initiated by an employee in response to an involuntary material reduction in hours that did not result in a loss of health coverage.
- An employer's decision not to renew an employee's contract if the employee was otherwise willing and able to continue the employment relationship and was not willing either to execute a contract with terms similar to those of the expiring contract or to continue employment without a contract (unless the parties understood at the time they entered into the expiring contract that the contract was for specified services over a set term and would not be renewed).
- Termination initiated by employee for a "good reason" — the employee must demonstrate that the employer's actions (or inactions) resulted in a material negative change in the employment relationship analogous to a constructive discharge.
- An involuntary termination of employment including participation by an employee in a "window program" meeting the requirement of Treas. Reg. § 31.3121(v)(2)-1(b)(4)(v) under which employees with impending terminations of employment are offered a severance arrangement to terminate employment within a specified period of time.

An involuntary termination does *not* include any of the following situations:

- A retirement, unless all the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's employment, that the employee was willing and able to continue employment, and that the employee had knowledge that the employee would be terminated absent the retirement.
- An employee's termination due to general concerns about workplace safety unless the constructive discharge criteria listed above can be met.
- A departure due to the personal circumstances of the employee unrelated to an action or inaction of the employer, such as a health condition of the employee or a family member, inability to locate daycare, or other similar issues, absent the employer's failure to either take a required action or provide a reasonable accommodation.
- An employee initiated termination due to a child being unable to attend school or because a child-care facility is closed due to COVID-19.

  Note: If the individual maintains the ability to return to work, and the facts and circumstances indicate that it is actually a temporary leave of absence such that the employee and employer intend to maintain the employment relationship, then it can be characterized as a reduction in hours (therefore making the individual potentially eligible for COBRA premium assistance).
- The death of an employee.

What Constitutes Eligibility for Other Group Health Plan Coverage or Medicare?

Under Notice 2021-31, COBRA premium assistance **is** available to an individual who is eligible for another group health plan but is not permitted to enroll in that plan (for example, due to being outside the open enrollment period or during a waiting period). The individual remains eligible for COBRA premium assistance until the first available enrollment period that occurs on or after April 1, 2021.

Example: Jason was involuntarily terminated by his employer on December 5, 2019. Upon losing coverage, he could have enrolled in his spouse's employer's group health plan outside of open enrollment as a HIPAA special enrollment event. Jason did not enroll in the spouse's employer's group health plan within the special enrollment period. Jason would be eligible for COBRA premium assistance under his former employer's plan until he was permitted to enroll in his spouse's employer's group health plan (e.g., at the next open enrollment). At that point Jason would lose eligibility for premium assistance.

Note: Typically, individuals have 31 or 60 days from the HIPAA special enrollment event (e.g., losing other group health plan coverage) to enroll in coverage under another group health plan outside of open enrollment. However, under the Joint Notice and EBSA Disaster Relief Notice 2021-01, this deadline has been extended for up to one year, so many of the individuals in this circumstance would still be able to enroll in a spouse's plan under the extended special enrollment deadlines — making them ineligible for the COBRA premium assistance.

Additionally, if a potential Assistance Eligible Individual was covered by another group health plan prior to April 1, 2021, but is no longer covered (or eligible to be covered) by that group health plan, the individual would still be eligible for COBRA premium assistance provided the individual elects COBRA coverage during the second extended election period.

TH COMMENT: Eligibility for another group health plan includes circumstances in which the spouse or dependent child would be required to pay the full cost of that group health plan coverage. Similarly, Notice 2021-31 confirms that if an individual is eligible for Medicare but not enrolled in Medicare, they are ineligible for premium assistance.

Coverage Under an HRA

Notice 2021-31 confirmed that eligibility for coverage under a Health Reimbursement Arrangement (HRA) would be considered eligibility for coverage under another group health plan and thus disqualify an individual from premium assistance, unless the HRA qualifies as a health flexible spending account (FSA) under Code Section 106(c)(2) (thereby making it an excepted benefit).

To qualify as a health FSA, the maximum amount of reimbursement that is reasonably available to a participant for the coverage must be less than 500 percent of the value of that coverage. The maximum amount of reimbursement that is reasonably available would generally be the balance of the HRA, and the value of the HRA coverage would generally be the applicable premium for COBRA continuation of the HRA coverage.

"Self-Certification" of Premium Assistance Eligibility

Notice 2021-31 confirms that plans can require individuals to provide a self-certification or attestation regarding their eligibility status with respect to a reduction in hours or involuntary termination of employment, as well as eligibility for other group health plan coverage or Medicare. To claim the tax credit, plans must maintain in their records either a self-certification or attestation from the individual regarding the individual's eligibility status, or other records to substantiate that the individual was eligible for the COBRA premium assistance. Importantly, plans may rely on an individual's attestation regarding a reduction in hours, involuntary termination or eligibility for other coverage, unless the plan has actual knowledge that the individual's attestation is incorrect. Plans can use the DOL's model *Request for Treatment as an Assistance Eligible Individual* for this purpose.

TH COMMENT: Employers with knowledge that an employee's termination was not involuntary should not claim the credit, even if the individual self-certifies that the termination was voluntary.

Second Qualifying Events/ Disability Extensions

It was unclear from the ARP, and DOL FAQs/model notices, how premium assistance interacts with an extension of COBRA coverage due to a second qualifying event or an extension due to a disability. Notice 2021-31 provides the following clarity:

- An individual whose *original* qualifying event was a reduction in hours or involuntary termination, and who elected COBRA (and remained enrolled in COBRA) and then experienced a second qualifying

event (e.g., a divorce), disability extension or an extension under State mini-COBRA *is eligible* for the COBRA premium assistance to the extent the additional periods of coverage fall between April 1 and September 30, 2021.

Example: Jill, a covered employee, and her spouse Mark experienced a qualifying event which was Jill's involuntary termination, causing a loss of group health plan coverage on September 1, 2019. Jill and Mark both elected COBRA coverage (which would normally last for 18 months until February 1, 2021). Jill and Mark divorced on January 1, 2021 and notified the COBRA Administrator of the divorce. The divorce was considered a second qualifying event, entitling Mark to an additional 18 months of COBRA coverage (for a total of 36 months from the date of the qualifying event, until August 1, 2022). Mark would be eligible for the COBRA premium assistance from April 1 to September 30, 2021.

TH COMMENT: DOL model notices do not include reference to such individuals. We hope the DOL will release additional guidance with regard to the plan's notice obligation to any individuals who may qualify for premium assistance under this rule. In the meantime, plans should ensure that their COBRA administrators are, at the very least, aware of this in the event that any potential Assistance Eligible Individuals contact the plan.

- If an individual *originally* loses coverage due to a qualifying event that was not a reduction in hours or involuntary termination (e.g., a divorce or dependent child turning age 26), and then the covered employee later loses coverage due to a reduction in hours or involuntary termination, that individual (i.e., the spouse or dependent who is now on COBRA) is not eligible for premium assistance.

Offer of Retiree Health Coverage

If retiree major medical coverage is offered under the *same* group health plan as the COBRA coverage, then the offer of retiree major medical coverage has *no* impact on eligibility for premium assistance (i.e., the individual is still eligible for premium assistance if they experienced a reduction in hours or involuntary termination). However, if retiree major medical coverage is offered under a separate group health plan than the COBRA coverage, the individual is *not* eligible for COBRA premium assistance. Additionally, retiree coverage may be treated as COBRA coverage for which premium assistance is available if the retiree coverage is offered under the same group health plan as the coverage made available to similarly situated active employees. Note: See above for a discussion of the impact of eligibility for a retiree HRA on premium assistance eligibility.

TH COMMENT: After the passage of the Affordable Care Act, many plan sponsors formally separated their active employee and retiree group health plans (e.g., separate plan documents, separate 5500s). Such eligibility for separate retiree group health plan coverage would disqualify an otherwise eligible individual from COBRA premium assistance.

When Does Premium Assistance Begin?

An Assistance Eligible Individual is entitled to receive premium assistance as of the first applicable period of coverage (usually one month) beginning on or after April 1, 2021. An Assistance Eligible Individual may waive COBRA coverage for any period before electing to receive premium assistance, including retroactive periods of coverage beginning prior to April 1, 2021.

Example: Julia experienced a qualifying event that was a termination of employment on July 31, 2020. Julia did not elect COBRA coverage at that time. On May 1, 2021 Julia received the ARP Notice of the extended election period. Julia has 60 days to elect premium assistance COBRA. Assuming Julia is not eligible for other group health plan coverage or Medicare, Julia can elect COBRA to start as of August 1, 2020 (Julia would owe COBRA premiums for August 2020 through March 2021), or April 1, 2021, May 1, 2021, or June 1, 2021.

Impact on Extended Plan Deadlines Due to COVID-19

EBSA Disaster Relief Notice 2021-01 provides an extension to the time period to elect COBRA and pay COBRA premiums for up to one year, due to the COVID-19 pandemic. IRS Guidance clarifies that this extension does *not* apply to the ARP extended election period. An Assistance Eligible Individual must elect subsidized COBRA within 60 days of receiving the notice of the extended COBRA election period, or they will lose the right to receive subsidized COBRA.

IRS guidance further clarifies that Assistance Eligible Individuals who are also eligible for the extended period to elect retroactive COBRA (i.e., unsubsidized) under EBSA Disaster Relief Notice 2021-01, must decide, when electing subsidized COBRA, whether they also want to elect retroactive unsubsidized COBRA and pay any associated premiums. (Note that the payment of COBRA premiums is subject to the COVID-19 deadline extensions.) If an Assistance Eligible Individual elects subsidized COBRA beginning on or after April 1, 2021 (but not retroactive unsubsidized COBRA), then they will lose their right to elect retroactive unsubsidized COBRA under EBSA Disaster Relief Notice 2021-01.

> **Example:** On March 1, 2020 Sam became eligible for COBRA due to a qualifying event that was an involuntary termination of employment, and he received a COBRA election notice that same day. Sam did not elect COBRA coverage at that time. Sam would normally have 60 days from this date to elect COBRA, but under EBSA Disaster Relief Notice 2021-01 Sam has an extension of up to one year to make this election. On April 30, 2021 Sam received a notice of the extended COBRA election period under the ARP and elected subsidized COBRA beginning on April 1, 2021. After July 30, 2021 (i.e., 60 days from the receipt of the notice of the extended election period), Sam would no longer be eligible to elect retroactive COBRA coverage beginning on December 1, 2020, despite the extension available in EBSA Disaster Relief Notice 2021-01.

Claiming the Premium Assistance Credit

While the federal government pays for the COBRA premium assistance, plan sponsors must front the cost of COBRA coverage for Assistance Eligible Individuals and will be required to pay any required premiums to carriers for any insured coverage. Moreover, for any Assistance Eligible Individual who makes a COBRA premium payment for any amount due during the period between April 1 and September 30, 2021, the plan must refund such payment(s) no later than 60 days after the date the Assistance Eligible Individual made the payment.

The employer (or multiemployer plan or insurer) becomes entitled to the credit on the date it receives the Assistance Eligible Individual's election of COBRA coverage. At that time, the employer will be entitled to the credit for premiums not paid by the Assistance Eligible Individual due to premium assistance for any months of coverage that began before that date. The employer will also be entitled to a credit for the amount of the premium not paid by the Assistance Eligible Individual at the beginning of each subsequent month.

> **Example:** On June 17, 2021 an employer receives an election of subsidized COBRA coverage from an Assistance Eligible Individual who elects COBRA to start as of April 1, 2021. As of June 17, the employer is entitled to a credit for the months of April, May and June. The employer will become eligible for a credit for July coverage as of July 1, 2021, for August coverage on August 1, 2021, and for September coverage on September 1, 2021 (assuming the Assistance Eligible Individual remained eligible for premium assistance for this entire period).

Notice 2021-31 permits a third-party payer (such as a Professional Employer Organization) to claim credit for the premium assistance if that third-party payer (i) maintains the group health plan; (ii) is considered the sponsor of the group health plan and is subject to the applicable DOL COBRA guidance (including providing the COBRA election notices to qualified beneficiaries); and (iii) would have received the COBRA premium payments directly from the Assistance Eligible Individuals were it not for COBRA premium assistance.

To claim the credit, the employer (or multiemployer plan) must report the number of individuals receiving subsidized COBRA and the resulting credit on the designated lines of Form 941 ("Employer Quarterly Federal Tax Return") which is filed quarterly. The employer (or multiemployer plan) may request an advance of the credit by filing the Form 7200 ("Advance Payment of Employer Credits Due to COVID-19"). The employer (or multiemployer plan) will need to file the Form 941 by the following deadlines:

Premiums for April – June:	July 31, 2021
Premiums for July – September:	October 31, 2021

The Amount of the Premium Assistance Credit

The amount of the credit will be equal to the COBRA premiums not paid by Assistance Eligible Individuals for the quarter and *does not include any amount of subsidy that the employer would have otherwise provided*. Under Notice 2021-31, an employer that previously charged less than the maximum premium amount allowed under COBRA can increase the premium for similarly situated Qualified Beneficiaries (provided it follows the rules prescribed in the COBRA regulations) and receive the premium assistance credit for that increased amount.[1]

For COBRA-like coverage provided to domestic partners or any other individual who does not qualify as a Qualified Beneficiary under federal law (such as a spouse or child added by a Qualified Beneficiary during open enrollment while on COBRA coverage), the employer (or multiemployer plan) cannot receive a credit for the additional amount of the COBRA premium that is attributable to the individual who is not a Qualified Beneficiary.

> **Example:** A Qualified Beneficiary while enrolled in COBRA adds a spouse and child during open enrollment. The employer would only be able to receive a credit for the amount of the COBRA premium for self-only COBRA coverage, not the family premium because the spouse and child are not Qualified Beneficiaries and therefore are not eligible for premium assistance (as the spouse and child were not covered by the employer's group health plan on the day before the qualifying event).

If you have any questions regarding these matters, please contact your Trucker Huss attorney or the author.

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[1] Treasury regulation §54.4980B-8,Q&A-2(b)(1) provides that a plan can increase the amount it requires to be paid for a Qualified Beneficiary's COBRA coverage only in three specific circumstances. To increase the premium for similarly situated COBRA premiums during the COBRA premium assistance period, the plan sponsor would need to follow those normal rules.

Mitigating Fiduciary Risk: Lessons Learned About the Prudent Person Rule After Fifteen Years of Fee Litigation

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JULY 2021

The uptick in lawsuits now commonly referred to as "excessive fee" fiduciary breach litigation began on September 11, 2006, when a St. Louis firm, Schlichter Bogard & Denton, filed its initial tranche of lawsuits against the fiduciaries of multiple large corporate 401(k) plans. In the fifteen years since those initial cases were filed, excessive fee lawsuits have become ubiquitous — at times numbering hundreds of cases filed per year — as more and more plaintiffs' firms enter this space. Many of the complaints in these cases are now formulaic, and plaintiffs have attacked fiduciaries of participant-directed retirement plans (401(k) or 403(b) plans) which range in size from tens of millions to multiple billions in assets. Plaintiffs in these excessive fee lawsuits commonly allege, among other claims, that plan fiduciaries breached their duty of prudence by failing to adequately monitor the cost and performance of their plans' investment options.

This excessive fee litigation has encouraged the reexamination of fiduciary best practices. Although the facts underlying these cases vary, the fundamental questions in each case pertain to the process by which the fiduciaries carried out their responsibilities. As courts have grappled with questions of fiduciary responsibility, a body of case law has developed that provides valuable guidance on methods plan fiduciaries may use to mitigate their risk if faced with a lawsuit or government investigation. This article addresses the duty of prudence in monitoring plan investments, thereby mitigating fiduciary risk through the lens of that body of case law.

Prudent Person Rule

Section 404 of the Employee Retirement Security Income Act of 1974, as amended (ERISA) sets forth the primary responsibilities of an ERISA fiduciary. These responsibilities include the Prudent Person Rule, which is a primary focus in this excessive fee litigation. This rule requires that plan fiduciaries act with the care, skill, prudence and diligence under the then-prevailing circumstances that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character with like aims. Put simply, this rule requires that a plan fiduciary act like a reasonable fiduciary would act in the same circumstances.

In evaluating whether a fiduciary has breached its duty of prudence, courts focus on the merits of the transaction at issue (e.g., the selection, removal, or retention of an investment option) and the thoroughness of the fiduciaries' investigation into the merits of that transaction. Relying on this responsibility to support their claims, plaintiffs have challenged the inclusion of a subset of a

plan's investment menu, alleging that the challenged funds are objectively overpriced in the market and did not perform in a manner that justified their cost.

Motions Challenging Plaintiffs' Common Claims

In most cases, fiduciaries have asked courts to dismiss claims based on the alleged imprudence of a plan's investment options through early motions to dismiss. To succeed on such a motion, fiduciaries must show that the plaintiffs' claims are legally insufficient (i.e., that plaintiffs have failed to plausibly allege that the fiduciaries acted imprudently). The decisions on those motions to dismiss have created a wide body of case law evaluating typical claims involving the investment funds' cost and performance — and have clarified certain fundamental principles of fiduciary oversight.

For example, it is common in these cases for plaintiffs to argue that plan fiduciaries offered too many actively managed investment options, because actively managed funds tend to carry higher investment management fees than passively managed index funds. In response to motions challenging the viability of these claims, courts have universally concluded that there is no requirement that plan fiduciaries offer any amount of passively managed options versus those that are actively managed.[1]

Likewise, courts have roundly agreed that the cost of a fund, alone, cannot demonstrate its imprudence and that the existence of a less expensive fund is not evidence of imprudence. Plan fiduciaries are not required to scour the market for the cheapest possible options and may offer funds for reasons other than cost.[2]

In order to even state a viable imprudence claim, courts have found that plaintiffs must plausibly allege that the challenged funds were not only overpriced but also performed poorly compared to a viable benchmark. To support their underperformance claims, plaintiffs typically rely on data that overemphasizes periods of comparative underperformance by cherry-picking fixed points in time that fit with their claims (i.e., those that include lower relative returns). Courts are increasingly dismissing claims based on these types of self-serving hindsight performance allegations and have reaffirmed that fiduciaries may measure performance based on long-term periods.[3]

Two Bench Trials Evaluate Prudence Process

Decisions reached after two rare bench trials in the *Sacerdote v. New York University*, 328 F.Supp.3d 273, 283 (S.D. N.Y., 2018) and *Wildman v. American Century Services, LLC*, 362 F. Supp. 3d 685 (W.D. Mo., 2019) cases provide valuable insight into what courts consider to be a prudent process.

In *NYU*, the court issued an order in favor of the defense following an eight-day bench trial. In reaching its decision, the court looked not only to the fiduciaries' investigation procedures, "but also to the methods used to carry out those procedures as well as the thoroughness of their analysis of the data collected in that investigation." The court found that the NYU investment committee was comprised of nine high-ranking employees who met quarterly and were advised by an expert investment manager. This investment advisor provided the NYU committee with materials on various financial aspects, which were typically distributed to committee members ahead of their meetings, and which the committee members reviewed. It also found that committee members asked the advisor questions and were provided with recommendations.

The court in *NYU* cautioned that committee members should not blindly rely on their advisor's counsel and should be familiar with the basic concepts relating to the plans. The committee, the court found, was required to independently verify the quality of the investment advice it received. While the court found that the "level of involvement and seriousness" that many of the committee members exhibited was potentially lacking, it concluded that between the advice provided by the investment advisor "and the guidance of the more well-equipped Committee members," the committee performed its role adequately.

In *American Century*, the district court issued a decision in the fiduciaries' favor after an eleven-day bench trial. In

reaching its decision, the district court found that the American Century plan offered a large number of investment options that consisted *entirely* of funds that American Century managed; and, between 2013 and 2016, the plan offered no passively managed options. Such facts are rife with potential litigation risk, as claimants in these lawsuits commonly allege that fiduciaries breached their duties by retaining any proprietary funds or an insufficient amount of typically lower-cost indexed investments.

The district court, however, looked past these potentially unfavorable facts to the American Century committee's process in overseeing the plan's investment menu. The court found that, upon being appointed to the committee, members received training about their fiduciary duties and were provided with plan documents and the plan's investment policy statement (IPS). The court found that the committee met regularly, at least three times per year, and that the meetings were active and productive. In rendering its decisions, the committee was guided by its IPS, which provided guidelines for fees and performance metrics. The committee considered those factors, along with expert information provided by its investment advisor and other consultants, while making its decisions about the plan's investment options.

Notably, the court specifically found that the American Century committee's IPS did not *require* the committee to remove a fund for failure to obtain certain metrics, but instead provided guidelines that gave the committee broad discretion to make decisions using their investment expertise.

The court looked to the "totality of the circumstances" because the "critical question is whether the defendants took into account all relevant information in performing [their] fiduciary duty under ERISA." Taking this information into consideration, the court concluded that the plan's fiduciaries did not act imprudently by offering only American Century funds and, for a time, no passively managed funds. The court held that the plan's fiduciaries did not act imprudently, because they appropriately considered whether to add, remove, or retain the plan's options.

Mitigating Risk

Decisions on early motions in excessive fee lawsuits tell us that a plan's investment funds need not be the cheapest on the market, that cost alone cannot demonstrate imprudence of an investment fund, and that performance should be evaluated on a long-term basis. Even in cases involving practices that would tend to carry high risk (such as *American Century*), courts still looked to the overall functioning of the committees' process in determining that the fiduciaries had not acted imprudently.

From these cases, we see that courts have recognized a prudent process in which administrators set up formal committees with active, interested and invested committee members. Plan fiduciaries are not required to be investment experts and may rely on the expertise of their investment advisors and other more investment-savvy committee members. Committees should meet regularly, at least 2–3 times per year; and committee members should receive and review investment review materials ahead of the meetings, thoroughly review those materials, ask questions of the committee's investment advisor to ensure full understanding of the materials, and render informed decisions about the plan's options. In addition, committee decisions should be guided by a well-drafted IPS that provides fiduciaries with broad discretion to render their decisions within a reasonable framework.

Importantly, plan fiduciaries should seek advice regarding their fiduciary duties and best practices on a regular basis. This should include routine education and regular engagement with experts on developing fiduciary standards and best practices. Once fiduciaries understand these fundamental aspects of a properly functioning committee, they will be equipped to put practices in place to solidify and follow processes that courts in this litigation have deemed prudent. This proper functioning should be well-documented — in minutes from committee meetings held at regular intervals and other materials — so that, should the fiduciaries ever face litigation, they are prepared to demonstrate their prudent practices.

It is uncertain where the focus of excessive fee litigation will lead as more and more plans are targeted in such

cases, but the pace of the filings has not diminished. Notably, on July 2, 2021, the United States Supreme Court granted certiorari in *Divane v. Northwestern University*, No. 18-2569 (7th Cir. 2020), a case often cited by fiduciaries in these cases to support their defense. The issues that the Court has agreed to consider in *Divane* are broad, and its decision could have a significant impact on this area of litigation. Nevertheless, what these cases teach us is that, by implementing proper processes — and instituting best practices for the benefit of their plans' participants — plan fiduciaries may build effective defenses to fiduciary breach claims.

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[1] *See White v. Chevron Corp.*, 752 F. App'x 453 (9th Cir. 2018); *Martin v. CareerBuilder, LLC*, No. 19-CV-6463, 2020 WL 3578022 (N.D. Ill. July 1, 2020); *Dorman v. Charles Schwab Corp.*, No. 17-00285-CW, 2018 WL 6803738 (N.D. Cal. Sept. 20, 2018); *Divane v. Northwestern Univ.*, 953 F.3d 980, 991 (7th Cir. 2020).

[2] See, e.g., *Wehner v. Genentech, Inc.*, No. 20-CV-06894-WHO, 2021 WL 507599 (N.D. Cal. Feb. 9, 2021); *Meiners v. Wells Fargo & Co.*, 898 F.3d 820 (8th Cir. 2018); *White,* 752 F. App'x 453.

[3] *Anderson v. Intel Corp. Inv. Policy Comm.*, No. 19-CV-04618-LHK, 2021 WL 229235 (N.D. Cal. Jan. 21, 2021).

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