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BENEFITS REPORT

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Tri-Agencies Provide Additional At-Home COVID-19 Testing Coverage Guidance

RYAN KADEVARI AND JENNIFER TRUONG

FEBRUARY 2022

On February 4, 2022, the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments) released additional guidance concerning group health plan and health insurance coverage of over-the-counter COVID-19 diagnostic tests ("OTC Tests"). The guidance complements an initial set of FAQs previously issued on January 10, 2022, which required group health plans and health insurance issuers to cover OTC Tests purchased on or after January 15, 2022. (The first round of guidance was addressed in a Trucker Huss Special Alert issued last month, "Health Plans and Insurers Required to Cover At-Home COVID Tests.")

In this new round of guidance, the Departments clarify (and even modify) certain provisions of the safe harbors that allow qualifying health plans and

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IN THIS ISSUE...

Trucker ✦ Huss Director Mary Powell to be Inducted as a Fellow of the American College of Employee Benefits Counsel

Trucker Huss, APC is pleased to announce Director Mary Powell was elected by the Board of Governors of the American College of Employee Benefits Counsel (ACEBC) to be inducted as a Fellow in the College at the College's Annual Dinner to be held at the Chicago Club in Chicago, IL, on September 17, 2022.

The ACEBC is an invitation-only organization of nationally-recognized employee benefits legal experts with twenty or more years of experience. Fellows of the ACEBC are selected by the College's Board of Governors from among employee benefits attorneys nominated for that honor and recommended for consideration by the Board's Membership Committee after considering the recommendations of regional screening committees. Selection as a Fellow reflects the Board's judgment that a nominee has made significant contributions to the advancement of the employee benefits field.

Six other senior or retired Trucker Huss attorneys are also Fellows of the ACEBC, including:

- Barbara Creed
- Brad Huss
- Kevin Nolt
- Charles Storke
- Lee Trucker
- Nick White

Mary Powell has over two decades of experience in all aspects of employee benefits, and is lauded by Chambers as having "exceptional client management skills" and a "very diligent and detail-oriented" approach. Currently, Mary's primary focus is assisting employers with the implementation of the Consolidated Appropriations Act (CAA) and the Patient Protection and Affordable Care Act (ACA), and drafting executive compensation and nonqualified deferred compensation plans. Mary assists employers with obtaining Private Letter Rulings from the IRS, and she submits comments to the IRS and Department of Labor both prior to the issuance of regulations and in response to proposed guidance issued by those agencies.

About Trucker Huss

With more than 30 legal professionals practicing solely in employee benefits law, Trucker Huss is one of the largest employee benefits specialty law firms in the country. Our in-depth knowledge and breadth of experience on all issues confronting employee benefit plans, and their sponsors, fiduciaries and service providers, translate into real- world, practical solutions for our clients. www.truckerhuss.com

issuers to limit certain OTC Test reimbursement amounts and quantities. The February 4, 2022 guidance also addresses limitations which are permitted to prevent fraud, as well as OTC Test reimbursements under health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs).

Background

Under Section 6001 of the Families First Coronavirus Response Act (FFCRA), group health plans and issuers must provide COVID-19 diagnostic testing without any cost-sharing, prior authorization, or other medical management requirements.

On January 10, 2022, the Departments issued FAQs confirming that the FFCRA requirement to cover diagnostic COVID tests also applies to OTC Tests that are available without a prescription or individualized clinical assessment from a health care provider. Although the first set of FAQs provided two safe harbors to incentivize plans and issuers to facilitate access to free OTC Tests, many employers and claims administrators had questions about application of the safe harbor requirements.

First, the January 10, 2022 guidance introduced a safe harbor (referred to in this article as the *direct coverage safe harbor*) which permits plans to cap reimbursement amounts at $12 per test or the actual cost of the test, whichever is lower. To qualify for the safe harbor, a plan must arrange for direct coverage of OTC Tests (i.e., participants are not required to seek reimbursement after purchasing OTC Tests) through both its pharmacy network and a direct-to-consumer shipping program. Although the safe harbor does not allow plans to restrict reimbursements to only OTC Tests provided through its preferred pharmacies or retailers, qualifying plans can limit reimbursement amounts for OTC Tests obtained outside the direct coverage program to no more than $12 per test. Under the safe harbor, a participant cannot be subject to any upfront out-of-pocket expenditures, prior authorization, or medical management requirements. In addition, plans must ensure participants have "adequate access" to OTC Tests. The guidance stated that adequate access is to be determined based on all relevant facts and circumstances.

Second, the guidance introduced another safe harbor (referred to in this article as the *quantity limit safe harbor*), which allows plans to limit the number of OTC Tests reimbursed without an order by a health care provider to 8 tests per 30-day period or calendar month. A plan or issuer satisfies the safe harbor rule if it provides coverage without cost-sharing for OTC Tests purchased without the involvement of a health care provider or a prescription. Like the direct coverage safe harbor, plans cannot impose upfront out-of-pocket expenditures, prior authorization, or medical management requirements on participants.

Subsequently, on February 4, 2022, the Departments issued another set of FAQs to clarify many of the requirements laid out in the January 10, 2022 guidance. Taken together, the two sets of FAQs provide plans with information to facilitate and promote access to testing, as discussed below.

Direct Coverage Safe Harbor Requirements Modified to Provide Plans and Issuers with Flexibility

As described above, the Departments' January 10, 2022 guidance introduced the direct coverage safe harbor for plans and issuers. The guidance specified that in order to ensure participants have adequate access to OTC Tests, plans and issuers were required to make OTC Tests available through a pharmacy network and a direct-to-consumer shipping mechanism to qualify for the direct coverage safe harbor. However, on February 4, 2022, the Departments modified the safe harbor requirement to provide plans and issuers with greater flexibility to determine how they will provide access to OTC Tests. Specifically, the Departments have walked back from the requirement that plans and issuers must provide access to OTC Tests through both a pharmacy network and a direct-to-consumer shipping mechanism. Instead, the Departments now state that adequate access will "generally" require that OTC Tests are available through at least one direct-to-consumer shipping mechanism and at least one in-person mechanism — although the determination will remain a facts-and-circumstances test. The February 4, 2022 FAQs also provide additional examples of "direct coverage" mechanisms, including direct-to-

consumer shipping programs that allow online or telephone ordering; and the ability to obtain OTC Tests through a plan's pharmacy network and through non-pharmacy retailers (e.g., the plan provides coupons for participants to redeem for OTC Tests without cost-sharing at specified retailers).

TRUCKER HUSS INSIGHT: In a footnote, the Departments confirmed that there may be circumstances in which a plan's direct coverage program could provide adequate access to OTC Tests without establishing both a direct-to-consumer shipping mechanism and an in-person mechanism. The Departments provide the example of a small employer plan covering employees that live and work in a "localized area" and obtain OTC Tests from a nearby location. However, this example also underscores that many employers, especially those with large workforces located across different counties and states, will likely still need to offer both direct-to-consumer shipping and in-person mechanisms for obtaining OTC Tests to qualify for the safe harbor. This guidance applies prospectively, beginning February 4, 2022.

Departments Clarify Direct-to-Consumer Shipping and In-Person Mechanisms

The February 4, 2022 guidance clarifies that a direct-to-consumer shipping mechanism refers to any program that provides access to OTC Tests without requiring participants to obtain the tests at an in-person location. A plan's direct-to-consumer shipping scheme can include online or telephone ordering, and it does not need to be exclusively provided through a single entity. For example, a plan that opts to provide in-person OTC Tests through specified retailers is considered to provide a direct-to-consumer shipping mechanism if those retailers also have online platforms where individuals can order tests for direct delivery. In addition, the guidance states that when providing OTC Tests through a direct-to-consumer shipping mechanism, plans must cover reasonable shipping costs in a manner that is consistent with other items or products that are provided by the plan via mail order.

The Departments also clarify that the direct coverage safe harbor does not require plans and issuers to make all OTC Tests available through its direct coverage programs. Accordingly, a plan can be considered to provide adequate access to OTC Tests even if only certain OTC Tests are available through the direct coverage program (e.g., if direct coverage of OTC Tests is limited to certain manufacturers, including those with whom the plan has a contractual relationship).

TRUCKER HUSS INSIGHT: The guidance clarifies that if OTC Tests are provided via a direct-to-consumer shipping program, the plan must cover reasonable shipping costs related to the tests. Even if a participant obtains an OTC Test outside the plan's direct coverage program (e.g., the participant goes to a non-preferred pharmacy or retailer and pays upfront for the OTC Test), the cost of the test includes the shipping and sales tax related to the purchase of the test. Accordingly, a plan must cover the cost of the OTC Test (including shipping costs and sales tax) up to the $12 per test limit. Notably, the Departments did not expressly address whether shipping and sales tax are included in the cost of OTC Tests if a plan or issuer has not established a direct coverage program.

Further, the Departments have consistently stated that whether there is adequate access under a plan's direct coverage program depends on all relevant facts and circumstances, including the location of participants, utilization rates of pharmacy networks, and whether participants are notified of and made aware of these locations. In the February 4, 2022 FAQs, the Departments indicate that they may request plans and issuers to provide information (e.g., the number and location of in-person options) to ensure that participants have adequate access. Accordingly, plans and issuers should be prepared to demonstrate that their direct coverage programs provide participants with adequate access based on the factors outlined in the Departments' guidance.

Note: The clarifying guidance discussed in this section also applies prospectively, beginning February 4, 2022.

Departments Clarify Impact of Temporary Supply Shortages on Safe Harbors

In the January 10, 2022 guidance, the Departments had stated that if a plan or issuer which is relying on the direct coverage safe harbor is at any time unable to meet the requirements of the safe harbor (e.g., due to delays in direct-to-consumer shipping), then the plan or issuer could not deny coverage or impose cost-sharing (e.g., limiting reimbursement amounts) for OTC Tests, including tests purchased from non-preferred sellers. Considering the high demand for and limited supply of OTC Tests, ensuring the consistent availability of OTC Tests appeared to be a substantial hurdle for many plans and issuers hoping to satisfy the safe harbor.

Fortunately, the February 4, 2022 guidance provides welcome clarification regarding plans' obligations to obtain OTC Tests. Now the Departments state that a plan or issuer is not considered out of compliance with the direct coverage safe harbor if it is temporarily unable to provide adequate access due to a supply shortage. Accordingly, plans and issuers may continue to cap reimbursements of tests purchased outside of the direct coverage program at $12 (or the actual cost of the test) while OTC Tests are temporarily unavailable. Furthermore, the Departments note that a plan is not out of compliance with Section 6001 of the FFCRA (requiring plans to cover OTC Tests) if a participant is unable to obtain at least 8 OTC Tests per 30-day or monthly period.

> **TRUCKER HUSS INSIGHT:** Although the Departments will not take enforcement action against a plan or issuer due to supply shortages, the relief only applies when a plan or issuer is temporarily unable to provide adequate access to OTC Tests. Unfortunately, the February 4, 2022 guidance does not define "temporarily" or provide any examples illustrating the scope of this relief.

Departments Permit Plans to Limit Reimbursements to OTC Tests Purchased from Established Retailers

In the January 10, 2022 guidance, the Departments acknowledged the possibility of fraud and abuse for OTC Test coverage. The guidance suggested that plans could require attestation that an OTC Test was purchased for personal use or require documentation verifying reimbursement as reasonable steps to address fraud and abuse. However, the guidance cautioned that overly burdensome attestation or documentation requirements would not be considered reasonable.

The February 4, 2022 guidance expands on additional tools and steps that plans and issuers can implement to discourage problematic behavior which could ultimately limit consumer access to OTC tests. The Departments expressly allow plans and issuers to implement policies that deny reimbursements for OTC Tests which are purchased from private individuals through person-to-person sales, online auctions, and resale marketplaces. Among other methods for stopping abuse, the Departments permit plans to require reasonable documentation of proof of purchase clearly identifying the seller (e.g., a receipt or UPC code).

> **TRUCKER HUSS INSIGHT:** In designing and implementing OTC Test reimbursement procedures, plans should carefully weigh the benefits of discouraging and preventing fraud against the burden imposed on participants. Further, any limitations or requirements for reimbursements must be clearly communicated to participants. In the February 4, 2022 guidance, the Departments made it clear that undue burdens or delays to reimbursement remain prohibited, and the ultimate goal continues to be facilitating participant access to OTC Tests.

OTC Tests Must Be Self-Administered and Self-Read

In their January 10, 2022 guidance, the Departments stated that OTC Tests are tests approved, cleared or authorized by the Food and Drug Administration (FDA) which can

be obtained without a prescription and used without a health care provider. The February 4, 2022 guidance clarifies that the coverage requirements set forth in the January 10, 2022 and February 4, 2022 FAQs only apply to COVID-19 tests that are approved or authorized to be self-administered *and* self-read without the involvement of a health care provider. Accordingly, diagnostic COVID-19 tests, like PCR tests, that rely on at-home collection but require samples to be mailed to a facility for analysis are not covered under the Departments' OTC Test guidance.

> **TRUCKER HUSS INSIGHT:** The Departments continue to remind plans that although OTC Tests are only eligible for coverage if both the test administration and reading can be performed at-home, a plan may still be required to cover diagnostic COVID-19 tests that require laboratory analysis of samples if the tests are ordered by an attending health care provider who has determined that the tests are medically appropriate. Accordingly, plans should keep in mind the existing rules regarding coverage of COVID-19 diagnostic testing under FFRCA and CARES — in addition to the OTC Test coverage rules.

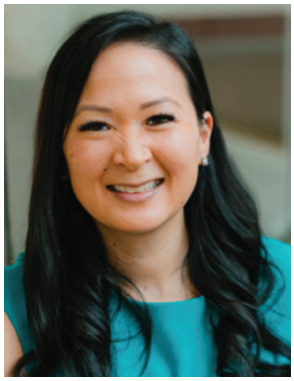
Departments Address Interaction Between OTC Test Coverage Requirements and Reimbursements under Health FSAs, HRAs, and HSAs

While it's not discussed in the January 10, 2022 guidance, the February 4, 2022 guidance confirms that OTC Tests are medical expenses that are generally reimbursable from Health FSAs, HRAs, and HSAs. Although plans and issuers are required to cover OTC Tests, the guidance clarifies that the cost (or the portion of the cost) of OTC Tests which were already paid or reimbursed by a plan or issuer cannot be reimbursed [again] through a Health FSA, HRA or HSA (i.e., participants cannot "double dip"). Accordingly, plans should proactively notify participants, beneficiaries, and enrollees not to seek reimbursement for OTC Tests via a Health FSA, HRA or HSA where the cost of an OTC Test has been (or will be) paid or reimbursed by a plan or issuer.

> **TRUCKER HUSS INSIGHT:** The February 4, 2022 guidance states that the cost "or the portion of the cost" of OTC Tests paid or reimbursed by a plan or issuer cannot be reimbursed as a qualifying medical expense under a Health FSA, HRA or HSA. This language indicates that the portion of costs that are not paid or reimbursed by a plan or issuer could still be reimbursed by a Health FSA, HRA or HSA. For example, if a participant obtains an OTC Test from outside the plan's direct coverage program, and the medical plan limited the reimbursement amount to $12, the portion of the OTC Test that was not covered by the plan may still be reimbursed by the participant's Health FSA.

Please contact us with any questions.

Missing Participants: The Search Continues



JOELLE TAVAN

FEBRUARY 2022

For a number of years, the Employee Benefit Security Administration (EBSA), the Department of Labor (DOL)'s branch responsible for administering and enforcing the fiduciary, reporting, and disclosure provisions of Title I of the Employee Retirement Income Security Act of 1974 (ERISA), has made missing plan participants one of its key areas of focus in its investigations program. Specifically, EBSA assesses whether plan fiduciaries and service providers are taking appropriate and effective action to locate participants and beneficiaries who are entitled to an ERISA plan benefit, but have not been responsive to routine plan communications.

ERISA has always required that plan fiduciaries maintain adequate plan records and distribute plan-related materials to participants and beneficiaries; however, there was no specific DOL guidance regarding missing participants, outside the context of plan terminations, until 2021, when the DOL issued such guidance in three distinct publications:

- "Best Practices for Pension Plans" guidelines, which describe practices plan fiduciaries should consider to mitigate missing participant issues;
- Compliance Assistance Release 2021-01, which outlines the general approach to be taken in investigations by EBSA Regional Offices under its Terminated Vested Participants enforcement project; and
- Field Assistance Bulletin 2021-01, which announces the DOL's temporary enforcement policy on terminating defined contribution plans' use of the Pension Benefit Guaranty Corporation (PBGC) Missing Participant Program.

Each of these important DOL publications is discussed below.

"Best Practices for Pension Plans" Guidelines

The Best Practices for Pension Plans guidance outlines best practices fiduciaries of defined benefit and defined contribution plans can follow to establish an appropriate process for locating missing participants and beneficiaries and ensuring that they timely receive the benefits to which they are entitled.

Identifying "Red Flags"

The guidance provides that the first step in addressing issues related to missing participants is for plan fiduciaries to identify "red flags" with respect to their plans, including the following conditions or circumstances:

- More than a small number of missing or nonresponsive participants.
- More than a small number of terminated vested participants who have reached normal retirement age, but have not started receiving their pension benefits.
- Missing, inaccurate, or incomplete contact information, census data, or both (e.g., incorrect or out-of-date mail, email, and other contact

information, partial social security numbers, missing birthdates, missing spousal information, or placeholder entries).

- An absence of sound policies and procedures for handling mail returned marked "return to sender," "wrong address," "addressee unknown," or otherwise, and undeliverable email.
- An absence of sound policies and procedures for handling uncashed checks (as reflected for example, by the absence of an accounting journal or similar record of uncashed checks, a substantial number of stale uncashed distribution checks, or failure to reclaim stale uncashed check funds in distribution accounts).

Examples of Best Practices

Next, the guidance describes general practices and procedures maintained by plans that had low numbers of missing and nonresponsive participants, as verified through DOL investigations. The DOL notes that these practices may not all be appropriate for every plan, but plan sponsors should consider them as part of reviewing their missing participant procedures, and implement changes as appropriate. Examples of the best practices identified by the DOL include the following:

Maintaining accurate census information for the plan's participant population

- Contacting participants, both current and retired, and beneficiaries on a periodic basis to confirm or update their contact information. Relevant contact information could include home and business addresses, telephone numbers (including cell phone numbers), social media contact information, and next of kin/emergency contact information.
- Including contact information change requests in plan communications.
- Flagging undeliverable mail/email and uncashed checks for follow-up.
- Maintaining and monitoring an online platform for the plan that participants can use to update contact information for themselves.
- Providing prompts for participants and beneficiaries to confirm contact information upon login to online platforms.
- Regularly requesting updates to contact information for beneficiaries, if any.
- Regularly auditing census information and correcting data errors.
- In the case of a change in recordkeepers or a business merger or acquisition by the plan sponsor, addressing the transfer of appropriate plan information (including participant and beneficiary contact information) and relevant employment records (e.g., next of kin information and emergency contacts).

Implementing effective communication strategies

- Using plain language and offering non-English language assistance.
- Stating upfront and prominently what the communication is about — e.g., eligibility to start payment of pension benefits, a request for updated contact information.
- Encouraging contact through plan/plan sponsor websites and toll free numbers.
- Building steps into the employer and plan onboarding and enrollment processes for new employees, and exit processes for separating or retiring employees, to confirm or update contact information, confirm information needed to determine when benefits are due and to correctly calculate the amount of benefits owed, and advise employees of the importance of ensuring that the plan has accurate contact information at all times.
- Communicating information about how the plan can help eligible employees consolidate accounts from prior employer plans or rollover IRAs.
- Clearly marking envelopes and correspondence with the original plan or sponsor name for participants who separated before the plan or sponsor name changed.

Missing participant searches

- Reviewing related plan and employer records for participant, beneficiary and next of kin/emergency contact information.
- Contacting designated plan beneficiaries and the employee's emergency contacts listed in the employer's records, in an effort to secure updated contact information.
- Using free online search engines, public record databases (such as those for licenses, mortgages and real estate taxes), obituaries, and social media to locate individuals.
- Using a commercial locator service, a credit-reporting agency, or a proprietary internet search tool to locate individuals.
- Attempting contact via United States Postal Service certified mail, or private delivery service with similar tracking features if less expensive.
- Attempting contact via other available means such as email addresses, telephone and text numbers, and social media.
- If participants are nonresponsive over a period of time, using death searches (e.g., Social Security Death Index) and, if death is confirmed, redirecting communication to beneficiaries.
- Reaching out to the colleagues of missing participants.
- Registering missing participants on public and private pension registries with privacy and cyber security protections (e.g., National Registry of Unclaimed Retirement Benefits).
- Searching regularly using some or all of the above steps.

Documenting procedures and actions

- Reducing the plan's policies and procedures to writing.
- Documenting key decisions and the steps and actions taken to implement the policies.
- Working with the plan recordkeeper to identify and correct shortcomings in the plan's recordkeeping and communication practices, including establishing procedures for obtaining relevant information held by the employer.

Terminated Vested Participants in Defined Benefit Plans (DOL Compliance Assistance Release 2021-01)

The DOL also made public an internal memorandum regarding EBSA's Terminated Vested Participants (TVP) enforcement project. The memorandum provides insight into EBSA's enforcement program, including the reasons for opening investigations, the type of information and documents investigators generally request from plan sponsors, and the systemic issues they look for in their audits.

The DOL states that an investigation may begin based on its review of a plan's Form 5500. For example, a Form 5500 reporting a large number of retired participants or TVPs who are entitled to future benefits might indicate systemic issues with the plan's administration, particularly issues related to keeping track of TVPs and beneficiaries, and timely distributing benefits. The DOL also notes that plan sponsor bankruptcies, mergers or acquisitions can result in the loss of participant data and, thus, may indicate a situation in which there exists a higher risk of missing participants.

The memorandum describes the various documents EBSA investigators generally request from plan sponsors at the beginning of an investigation, including plan documents, summary plan descriptions, participant census records noting the employment status of each participant and their contact information, and actuarial reports or other reports prepared by the plan's actuary. Investigators also request and examine plan procedures for communicating with TVPs and beneficiaries, and evaluate their policies and practices regarding the preparation and distribution of benefit statements and other participant communications. Investigators also seek information to determine whether plans are taking sufficient steps to address missing participants; they will examine internal

procedures and practices for reaching out to, and searching for, unresponsive TVPs, as well as contracts and experience with service providers who perform recordkeeping and missing participant searches for the plans.

ESBA investigators will then examine the provided documents and other relevant information to identify compliance issues, such as:

- Systemic errors in plan recordkeeping and administration that create a risk of TVPs failing to enter pay status.
- Inadequate procedures for identifying and locating missing TVPs or their beneficiaries.
- Inadequate procedures for contacting TVPs nearing normal retirement age to inform them of their right to commence benefit payments.
- Inadequate procedures for contacting TVPs who are not in pay status at, or near, the date that they must commence receiving required minimum distributions.
- Inadequate procedures for addressing uncashed distribution checks.

The DOL concludes its memorandum on a positive note, by confirming that absent significant errors or widespread fiduciary breaches, and subject to fiduciaries taking appropriate corrective actions to remedy compliance shortfalls, EBSA generally will not cite plan fiduciaries with specific ERISA violations.

PBGC Missing Participants Program (DOL Field Assistance Bulletin 2021-01)

In conjunction with the "Best Practices for Pension Plans" Guidelines and Compliance Assistance Release 2021-01, the DOL also issued Field Assistance Bulletin 2021-01 (FAB) 2021-01, which announces a temporary enforcement policy on terminating defined contribution plans' use of the PBGC Missing Participants Program (the "Program"). The temporary enforcement policy applies to fiduciaries of terminating defined contribution plans and qualified termination administrators (QTAs) of abandoned individual account plans.

As background, the DOL currently provides a fiduciary safe harbor under DOL Reg. § 2550.404a-3 for use in making distributions to missing and nonresponsive participants and beneficiaries from terminated defined contribution plans and abandoned plans. The safe harbor generally requires that distributions be rolled over to an IRA, although in limited circumstances fiduciaries may make distributions to certain bank accounts or to a state unclaimed property fund. If the safe harbor requirements are met, the plan fiduciary or QTA will be deemed to have satisfied ERISA's requirements with respect to the distribution of benefits.

The PBGC established the Program to hold retirement benefits for missing participants and beneficiaries in most terminated plans and to help participants and beneficiaries receive their benefits. For many years, the Program covered only PBGC-insured single-employer defined benefit plans. The Program was later expanded to cover defined contribution plans that terminate on or after January 1, 2018. See Trucker Huss's article on the Program.

In FAB 2021-01, the DOL states that, pending further guidance, it will not pursue fiduciary breach claims against plan fiduciaries or QTAs that transfer missing participants' accounts to the Program, instead of using other available mechanisms (e.g., safe harbor IRAs, escheatment — provided that certain conditions are met, and the fiduciary or QTA complies with FAB 2021-01 and acts in good faith in reasonably interpreting the law. The DOL also indicates that, unless the terms of the plan do not permit it, the fee charged by the PBGC for certain accounts transferred to the Program may be paid for from the transferred account.

The DOL notes, however, that the temporary enforcement policy does not preclude the DOL from pursuing ERISA violations for failure to diligently search for participants and beneficiaries prior to transferring their accounts to the PBGC or for failure to maintain plan and employer records. Additionally, the temporary enforcement policy does not legally protect plan fiduciaries or QTAs from civil claims made by plan participants or their beneficiaries. Nonetheless, the DOL's announcement is welcome news for fiduciaries and QTAs who opt to take advantage of the Program.

Action Steps

In light of the DOL's three-part guidance, plan fiduciaries of defined benefit and defined contribution plans are encouraged to review their administrative processes and procedures, and to work with their plan recordkeepers to ensure appropriate measures are taken to address and reduce missing participant issues. Those measures should be clearly described in a written policy which may include, for example, the plan's process to keep accurate census information for its population and the procedures for searching for missing participants. The policy should also describe the plan sponsor's procedures for handling uncashed checks. Additionally, on-going efforts to locate missing participants should be documented so that, in the event of a DOL investigation, plan fiduciaries can demonstrate their diligent efforts to search for missing participants and pay plan benefits.

Please contact the author or your Trucker Huss attorney if you have any questions.

FIRM NEWS

On February 24, **Mary Powell** will discuss healthcare compliance at the *2022 Joint TE/GE Council Employee Plans Virtual Annual Meeting*. The Joint TE/GE Council facilitates communication between the TE/GE Division of the Internal Revenue Service and employee benefits practitioners.

On March 15, Mary will be a panelist for a Joint Committee on Employee Benefits of the ABA Webinar, *OTC Covid-19 Tests — Required Benefits and Potential Issues.* She will discuss the requirements placed on group health plans to cover over-the-counter COVID-19 tests, the FAQs issued by the Departments, and how employers can navigate compliance.

On February 22, Mary presented a Trucker Huss Webinar, *For Health Plan Sponsors — How to Use the CAA to Negotiate a Better Administrative Services Agreement*. She looked at the ways plan sponsors can use the new rules to assist in drafting better agreements with healthcare vendors, and discussed the No Surprises Act of the CAA and the transparency rules issued under the CAA and the Affordable Care Act.

On December 15, Mary presented a Trucker Huss Webinar, *Pharmacy Benefit Managers (PBMs) — A Secret Behind High Drug Costs.* Prescription drug costs keep escalating. Mary discussed what drives these high costs and where PBMs fit into the drug pricing puzzle.

On February 24, **Clarissa Kang** will be a panelist for the the Joint Committee on Employee Benefits of the ABA. The webinar, *Pension and Welfare Plan Overpayments — What Plans and Participants Need to Know*, will provide guidance to ERISA attorneys on employee benefit plan overpayments both from the participant's and the plan's perspectives.

On March 9, **Marc Fosse** will co-present a Strafford Live Webinar entitled, *Structuring Deferred Compensation: Plan Options and Key Considerations for Employee Benefits Counsel*. This CLE webinar will provide employee benefits counsel and advisers with a detailed review of the ERISA, IRS, and DOL regulations to consider in structuring deferred compensation plans.

On March 28, Marc will be discussing *Section 457(f): Compensation Guide for Nonprofits* in a Lorman webinar. He will offer insights on the implications for exempt organizations when structuring executive compensation plans.

On February 3, **Angel Garrett** was a panelist for the Employee Benefits Litigation Update at the ABA Virtual 2022 Midyear Tax Meeting. The panel reviewed recent litigation and decisions of interest in the area of employee benefits law.

On December 7, **Brad Huss**, **Nick White**, **Robert Gower**, **Dylan Rudolph,** and **Catherine Reagan** presented a Trucker Huss Webinar, *Cybersecurity Guidance and New Proposed Rule Regarding ESG Investments from the Department of Labor.* The panel evaluated recent guidance on cybersecurity for plan sponsors, fiduciaries, recordkeepers and participants, as well as the DOL's proposed rule regarding consideration of environmental, social, and governance (ESG) factors in management of plan investments (including discussion for plan fiduciaries interested in offering ESG investments).

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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