Our 2026 Benefits Briefing Will Begin Shortly

Agenda:

- The Latest in Health & Welfare
- Issues Impacting Qualified Plans
- Litigation Lessons and Minimizing Risks
- Executive Compensation: Recent Trends and Hot Topics
- Fiduciary Trends in Retirement Plans

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Welcome to our 2026 Benefits Briefing

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The Latest in Health & Welfare

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Agenda

- Direct-to-Consumer/Direct-to-Employer/TrumpRx Drug Plans
  - an explanation of these new products, how employers can offer them and issues to be aware of prior to adopting these programs
- GLP-1s
  - updates on legal issues to consider when adding these drugs to a health plan for weight loss
- Voluntary Health and Welfare Plans
  - a discussion of recent class action lawsuits filed regarding voluntary plans
- New Proposed Pharmacy Benefit Manager Fee Disclosure Rule from the Department of Labor (DOL)
- Pharmacy Benefit Manager provisions in the Consolidated Appropriations Act, 2026 (CAA 2026)

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Direct-to-Consumer/Direct-to-Employer/TrumpRx Drug Plans

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Direct-to-Consumer Model

- The primary goal of the direct-to-consumer (DTC) programs is to allow individuals to purchase medications directly from the pharmaceutical companies at discounted rates
- DTC programs do not integrate with employer-sponsored health plans
- The cost paid by the individual for the drugs doesn't apply to their health plan deductible and is not included in their health plan medical records
- Examples of the discounted rates through DTC programs for weight loss drugs:
  - The cost of the drug under the group health plan is around $1,200 for a one-month supply
  - DTC Price:
    - Ozempic at $199 per month
    - Zepbound at $299 per month
    - Wegovy pill at $150 per month

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Direct-to-Consumer Model

- One of the first DTC programs was launched by Eli Lilly and Company
- In 2024, Eli Lilly and Company announced LillyDirect, which is an online platform that offers individuals direct access to certain drugs, including Zepbound
- Eli Lilly partnered with telehealth companies that connect individuals with healthcare professionals who can prescribe Zepbound for the treatment of obesity
- The prescription for Zepbound is sent from the telehealth provider to Eli Lilly, which then contracts with entities, such as Amazon, to have that drug sent directly to the individual's home
- Pfizer has launched a similar program for certain drugs—PfizerForAll—and stated that it will offer certain specialty branded drugs at discounts of 50% on average and up to 85%
- At this point, the Trump administration has stated that it has secured deals with Amgen, Bristol Myers Squibb, Boehringer Ingelheim, Genentech, Gilead Sciences, GSK, Merck, Novartis, and Sanofi

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Direct-to-Consumer Model

- Given the decreased costs of certain drugs offered through these DTC programs, employers are considering ways to utilize these programs
- For example, an employer may amend its health plan to eliminate coverage for GLP-1s for the treatment of obesity
- The employer will reimburse an employee for the cost of that drug obtained through the DTC program under a health reimbursement account (HRA)
- HRAs that reimburse drugs obtained through DTC programs must be specifically designed to meet all applicable legal requirements
- We will address the HRA requirements later in this presentation

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Direct-to-Consumer

- These DTC programs cutout the middleman—the pharmacy benefit manager (PBM)
- One concern for employers is whether such DTC HRA would violate the terms of the contract between the PBM and the plan sponsor
- Almost all PBM agreements contain an exclusivity provision—meaning that the employer agrees that its health plan will only cover drugs that are provided through the PBM. If this provision is violated, the contract often states that the PBM can void all of the pricing guarantees in the agreement
- In addition, most PBM agreements contain a provision that if certain drugs are removed from the formulary, the PBM has the right to renegotiate all of the drug pricing provisions in the agreement
- Before adopting any program that reimburses the cost of drugs obtained by an employee through a DTC program, the employer should first review its agreement with the PBM to ensure such a program would not violate the terms of the agreement
- **Note**: any new amendments to a PBM agreement and any new PBM agreement should address DTC programs

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Direct-to-Employer

- Some drug companies state that they will also offer Direct-to-Employer (DTE) programs
  - There is little information on these
- **The pharmaceutical companies want the DTC and DTE programs to work**
  - They will capture more money by cutting out the PBM
  - They have gained favor with the Trump administration, and that includes more favorable terms on tariffs—currently, some pharmaceutical companies have secured immunity for 3 years from potential tariffs based, in part, on the offering of the DTC and DTE programs
- Employers will not want to have separate agreements with each pharmaceutical company for these programs
- New vendors will be in this space that will assist employers to simplify the contracting process—we have already seen a few new vendors for the DTC HRAs

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TrumpRx

- TrumpRx.gov is a website that is designed to help individuals find discounted prices for high-cost, brand-name prescriptions
- There are only 43 drugs on the website at this point, with the majority of the drugs being fertility drugs and weight loss drugs
- The site does not directly sell drugs. Instead, consumers browse a list of discounted medicines and select one for purchase
- Once a drug is selected, the individual either receives a coupon that can be accepted at certain pharmacies or are routed directly to a drug manufacturer's website to purchase the prescription
- This does not appear to be that different than other companies that provide information on lower cost options, such as GoodRx (which is partnered with TrumpRx)

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Future of These Programs

- As explained on the next slides, employers may adopt HRAs as a way to utilize these DTC programs
- It is unclear how the DTE programs will work
- TrumpRx will likely be most beneficial for those without coverage looking for weight loss or fertility drugs or those who have coverage but the specific drug that is on TrumpRx is excluded from plan coverage

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GLP-1s

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GLP-1 Coverage

- Various FDA approved prescription medications are available for weight management use (e.g., Wegovy, Mounjaro, Zepbound)
- Currently, the cost to group health plans of GLP-1s for weight management can range up to $1,500 per month
- One in eight adults say they are currently taking a GLP-1 drug to lose weight
- Surveys show that 30-43% of large employers are covering GLP-1s for weight loss under their health plans
    - These employers viewed GLP-1s for weight loss having a “significant” impact on their prescription drug spending

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GLP-1 Cost Containment Strategies—Compliance Considerations

- **Coverage exclusions**
  - There are no federal mandates requiring a plan to cover GLP-1 medications for weight loss
  - A group health plan may face discrimination claims if it excludes GLP-1 coverage for weight loss under laws such as:
    - Americans with Disabilities Act (ADA)
    - Affordable Care Act Section 1557 Discrimination
    - Health Insurance Portability and Accountability Act (HIPAA) Discrimination

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GLP-1 Cost Containment Strategies—Compliance Considerations

- **Shifting cost sharing**
  - Impose higher co-pays for GLP-1s
  - Impose annual or lifetime limits on GLP-1 coverage
  - Exclude cost sharing amounts from participant out-of-pocket maximums
- **Keep in mind Affordable Care Act requirements**
  - Prohibit imposing annual and lifetime dollar limits on Essential Health Benefits (EHBs)
  - Require out-of-pocket maximums and counting EHBs against the out-of-pocket maximum
  - The Department of Labor, HHS, and Department of Treasury under Biden Administration had issued guidance stating their intent to propose ruling making that would require large and self-funded group health plans to treat all prescription drugs as EHBs
    - Review state benchmark plans—North Dakota includes GLP-1s for morbid obesity as an EHB

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GLP-1 Cost Containment Strategies—Compliance Considerations

- **Weight management programs**
  - Example: Employer's health plan subsidizes GLP-1 coverage for weight loss at 100% under employer major medical plan if employee participates in employer sponsored weight management program and demonstrates weight loss under program
- **Compliance considerations under:**
  - **HIPAA wellness rules for Health Contingent Program**
    - To satisfy wellness rules the program must
      - Be reasonably designed
      - Offer annual qualification
      - *Limit amount of incentive to 30% of the cost of coverage*
      - Provide reasonable alternative method to earn incentive
      - Provide notice of the reasonable alternative

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GLP-1 Cost Containment—Compliance Considerations

- **Weight management programs**
  - Example: Employer's health plan subsidizes GLP-1 coverage for weight loss at 100% under employer major medical plan if employee participates in employer sponsored weight management program and demonstrates weight loss under program. Program requires monthly lab work and meetings with a wellness coach
- **Compliance considerations under:**
  - **Americans with Disabilities Act (ADA)**
  - The ADA limits the circumstances in which an employer may make disability related inquiries or require medical examinations. These types of inquiries and exams are permitted under a "voluntary" wellness program

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GLP-1 Cost Containment—Compliance Considerations, cont'd

- Labwork may be considered a "medical examination" and questions from wellness coach may be "disability related inquiries"
- Incentive amount must be limited to an amount that would be considered "voluntary"
- Employer cannot limit the extent of benefits for employees who do not participate (i.e., gateway plan)

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GLP-1 Cost Containment—Compliance Considerations, cont'd

- **GLP-1 Health Reimbursement Arrangement**
- Employer may consider covering GLP-1s for weight loss through a Health Reimbursement Arrangement (instead of through major medical plan)
  - **ERISA Group Health Plan.** HRAs are ERISA group health plans and must comply with applicable laws
  - **Reimbursement of 213(d) Medical Care.** Health Reimbursement Arrangements reimburse IRS code section 213(d) medical expenses
    - IRS has stated that weight-loss program expenses will qualify as a medical expense that can be reimbursed through an HRA if it treats a specific disease diagnosed by a physician (e.g., obesity, heart disease, etc.)

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GLP-1 Cost Containment—Compliance Considerations, cont'd

- **Affordable Care Act.** To comply with the Affordable Care Act, the HRA must be "integrated" with other major medical plan coverage
- **HDHP/HSA Eligibility.** Design HRA such that it does not interfere with High Deductible Health Plan/Health Savings Account eligibility
  - Preventive care rules. Some argue that drugs used as part of obesity weight loss program may be considered "preventive care." This is an open issue
- **Impact on PBM Agreement.** Review PBM Agreement to determine whether this design will cause issues (e.g., whether removal of drug from formulary will give PBM right to renegotiate drug pricing provisions in the agreement)

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Voluntary Plan Litigation

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Voluntary Plan Litigation

- **What are voluntary plans?**
  - Employers often offer employees the opportunity to purchase supplemental benefits such as accident, critical illness, hospital indemnity, and cancer insurance
  - Employees pay the full cost for these supplemental benefits through payroll deductions
- **Are these types of plans subject to ERISA?**
  - The DOL regulations provide a safe harbor under which ERISA does not apply to voluntary insurance arrangements that meet specific requirements—including that employees pay the full premium and the employer has minimal involvement

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Voluntary Plan Litigation

- **ERISA Voluntary Plan Safe Harbor**
  - An employee welfare benefit plan does not include a group insurance program offered by an insurer to employees under which:
    - No contributions are made by the employer
    - Participation in the program is completely voluntary for employees
    - The sole functions of the employer with respect to the program without endorsing the program are to permit the insurer to publicize the program to employees and to collect premiums through payroll deductions; and
    - The employer receives no consideration in the form of cash or otherwise in connection with the program

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Voluntary Plan Litigation

- **Limiting employer endorsement is the key to not treating the program as an ERISA benefit. Examples of endorsement include:**
  - Employer involvement in plan design, eligibility requirements, negotiating insurance contract
  - Associating employer's name with the voluntary benefit, such as
    - designating the employer as plan administrator, plan sponsor, or trustee
    - having the insurance contract issued in the employer's name, or
    - distributing information that associates the voluntary plan with other ERISA benefits of the employer
  - Saying the benefit is subject to ERISA (e.g., Form 5500 filing)
  - Assisting employees with filing claims under the voluntary benefit plan

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Voluntary Plan Litigation

- **Employer may not receive consideration in the form of cash or otherwise**
  - Plaintiffs may assert that employers received some form of consideration for offering voluntary plan benefits
    - Free or discounted services for employer in recognition of the commissions that the consultants/brokers have received in connection with the voluntary benefit program

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Voluntary Plan Litigation

- In December of 2025, several class action lawsuits were filed against employers and their brokers/consultants for alleged breach of fiduciary duty related to their voluntary plan benefits
- Employer offered supplemental accident, critical illness, and hospital indemnity insurance benefits. The employer held these benefits out as “voluntary plan benefits” but included these benefits in its Form 5500 filings
- Complaints filed contend that plans at issue are ERISA plans and that the employers and brokers are plan fiduciaries
  - Allege that employer failed to:
    - Have a process in place to select or monitor the voluntary plan insurance carriers
    - Have a process in place to select or monitor brokers of voluntary insurance plans
    - Failed to ensure that broker’s commissions were reasonable
    - Did not ensure that the voluntary plan benefits were reasonably priced
  - Plaintiffs claim that they suffered financial harm when they overpaid for their voluntary plan benefits

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Voluntary Plan Litigation

- Employers should review voluntary plan benefit offerings and determine whether these benefits meet the DOL voluntary plan safe harbor
- If it is challenging to satisfy voluntary plan safe harbor, assess whether it makes sense to treat these benefits as ERISA plans and comply with ERISA requirements

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New DOL Proposed Pharmacy Benefit Manager Fee Disclosure Rule

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DOL Proposed Regulation

- On January 29, 2026, the Department of Labor (DOL) issued a proposed rule titled “Improving Transparency into Pharmacy Benefit Manager Fee Disclosure”
- The proposed rule would require PBMs and affiliated consultants and brokers to disclose information about their compensation to the fiduciaries of self-insured group health plans subject to ERISA
- The purpose of the rule is to provide greater transparency into contracts and arrangements with entities providing pharmacy benefit management services and affiliated brokers and consultants
- This will allow fiduciaries to have the information they need to determine whether their contracts or arrangements are reasonable

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DOL Proposed Regulation, cont'd

- The proposed regulation is issued under ERISA §408(b)(2). It provides an exemption from the prohibited transaction regulations for arrangements between self-funded plans and pharmacy benefit management service providers
- In general, ERISA §406 prohibits the furnishing of services between a self-insured group health plan and a party in interest to the plan, unless an exemption applies. Essentially, any service provider to a health plan is a party-in-interest.
- ERISA § 408(b)(2) provides an exemption for these arrangements IF:
  - the contract or arrangement is reasonable,
  - the services are necessary, and
  - no more than reasonable compensation is paid for the services
- The proposed regulation would provide a regulation-based exemption from this prohibited transaction rule

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DOL Proposed Regulation—Key Terms

- **Covered Plan**—Includes self-funded health plans but excludes fully insured plans
- **Covered Service Provider**—any service provider that enters into a contract or arrangement with a covered plan and expects to receive $1,000 or more in direct or indirect compensation in connection with providing pharmacy benefit management services or providing advice, recommendations, or referrals regarding the provision of pharmacy benefit management services

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DOL Proposed Regulation—Key Terms, cont'd

- Pharmacy Benefit Manager Services—this is a very broad term and includes any services necessary for the management or administration of plan's prescription drug benefits (includes a long list of examples) such as:
- negotiating rebates, fees, discounts
- establishing or maintaining formularies
- establishing or maintaining pharmacy networks
- processing and payment of claims for prescription drugs
- performing utilization reviews
- adjudicating appeals, and
- recordkeeping related to the prescription drug benefits

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DOL Proposed Regulation—Initial Disclosure

- A Covered Service Provider must disclose, to a responsible fiduciary, in writing, certain information no later than a date that is reasonably in **advance** of the date in which the contract or arrangement is entered, and extended or renewed (for extensions and renewals, 30 calendar days in advance is deemed reasonable)

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DOL Proposed Regulation—Initial Disclosure, cont'd

- The information for the initial disclosure includes:
  - Description of Services: A description of each pharmacy benefit management service or of the advice, recommendations, or referrals regarding the pharmacy benefit management services provided to the plan pursuant to the contract or arrangement
  - Direct Compensation: All direct compensation, both in the aggregate and by service, that is expected to be received on a quarterly basis
  - Manufacturer Payments: A description of the amount of payment, both in the aggregate and for each drug on the formulary, reasonably expected to be paid on a quarterly basis by the manufacturer or an aggregator, specifying both the amount that will be passed to the plan and the plan sponsor, and the amount that will be retained by the covered service provider

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DOL Proposed Regulation—Initial Disclosure, cont'd

- Spread Compensation: A description of the quarterly amount of spread compensation reasonably expected to be received, defined as the difference between the negotiated rate reasonably expected to be paid by the plan and the negotiated rate reasonably expected to be paid by the covered service provider to the pharmacy for dispensing drugs—both in the aggregate and for each covered drug on the formulary and for each pharmacy channel (*i.e.,* retail, mail order, and specialty pharmacy)
- Copay Claw-Backs: A description of the quarterly amount of copay claw-back compensation reasonably expected to be recouped from a pharmacy by a covered service provider, defined as the dollar amount of the difference between a copayment or coinsurance amount paid to the pharmacy by a participant and the reimbursement to the pharmacy
- Price Protection Agreements: A description of any inflation protection or price protection agreements that the covered service provider has with any drug manufacturer or other party in connection with prescription drugs dispensed under the service contract or arrangement.

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DOL Proposed Regulation—Initial Disclosure, cont'd

- Compensation for Termination of Service Contract or Arrangement: A description of any compensation that is reasonably expected to be received in connection with termination of the service contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination
- Description of Other Compensation: Any other compensation not disclosed, including the identification of the payer and the services for which the compensation will be received

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DOL Proposed Regulation—Initial Disclosure, cont'd

- Description of Formulary Placement Incentives:
  - A description of any formulary placement incentives and arrangements that has been entered with any drug manufacturer, along with an explanation of how the incentives and arrangements affect services and are aligned with the interests of the plan and/or its participants
  - For any drug on the formulary for which any payment will be made to the covered service provider by the manufacturer or aggregator, an identification of any reasonably available therapeutically equivalent alternatives, and the reason for omitting the alternatives from the formulary
  - If the covered service provider retains the authority to modify the formulary, an explanation for the reason for retaining such authority, the expected frequency of changes, and that the reasonable plan fiduciary will be notified in advance of any such modification that will have a material impact on the compensation under the arrangement (material is a defined term)

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DOL Proposed Regulation—Initial Disclosure, cont'd

- Drug Pricing Methodology: A description of the net cost to the covered plan of each drug on the formulary, for each pharmacy channel, expressed as a monetary amount
- Statement of Fiduciary Status: A statement that the covered service provider is providing services as a fiduciary, if applicable, as well as any activity or policy that may create a conflict of interest. For example, if such entity will benefit financially from drug substitution
- Statement of Audit Rights: A statement of the plan's right to audit these disclosures and the procedures for requesting such audit

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DOL Proposed Regulation—Semiannual Disclosure

- A covered service provider shall disclose to a responsible plan fiduciary, in writing, on a semiannual basis, "no later than 30 calendar days after the end of each six-month period beginning on the date the service contract or arrangement is entered" the following information with respect to the preceding six-month period: **direct compensation, manufacturer payments, spread compensation, copay claw-backs, price protection agreements and other compensation**
- If any of these categories of compensation materially exceeds the earlier estimate provided by the covered service provider—defined as a change greater than five percent (or a lower amount agreed to by the parties)—it must identify the amount of the overage and the reason for the overage
- Upon written request of the plan fiduciary, the covered service provider must provide any other information relating to the contract or arrangement that is required for the plan to comply with its reporting and disclosure obligations
- Lastly, it must include a statement of the plan's audit rights

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DOL Proposed Regulation

- All required disclosures must be "clear and concise, free of misrepresentation, and contain sufficient specificity to permit evaluation of the reasonableness of the contract or arrangement"
- Compensation amounts must also be expressed as a monetary amount and "contain sufficient information and specificity to permit evaluation of the reasonableness of the compensation received" by the covered service provider
- Covered service providers cannot impose "restrictions on the plan's use" of required disclosures—but can require any third parties that are provided information by the plan to sign "reasonable confidentiality agreements" to prevent the redisclosure of such information

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DOL Proposed Regulation—Right to Audit

- Frequency and Scope: Not less than once per year, the plan has the right to audit for the accuracy of these disclosures
- Auditor: The responsible fiduciary has the right to select the auditor
- Provision of Information: All reasonably necessary information must be made available, including contracts with retail pharmacies and drug manufacturers, subject to reasonable confidentiality agreements to prevent redisclosure
- Fees: The plan shall bear the responsibility for all expenses related to the selection and retention of the auditor. The covered service provider shall bear the cost of providing the required information
- Timing: The covered service provider shall confirm receipt of the audit request within 10 business days after the information is requested—and must provide the information within a commercially reasonable period
- Restrictions: There can be no restrictions on the right to conduct the audit, including the period of the audit, location of the audit, or the number of records provided, except that the scope of the audit may be limited to the period covered by the disclosures

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DOL Proposed Regulation—Exemption for Responsible Plan Fiduciary

- Exempts the responsible plan fiduciaries from liability under the prohibited transaction rules if they did not know that the covered service provider failed or would fail to make the disclosures and reasonably believed the regulation's requirements had been met
- Upon discovering the failure, requests in writing for the covered service provider to correct the failure (i.e., to furnish the required information or comply with the audit requirement)
- If the service provider does not comply with the request in 90 days, the plan fiduciary must provide notice to the DOL of the failure no later than 30 calendar days following the earlier of: (1) the covered service provider's refusal to correct the failure or (2) 90 calendar days after the written request is made
- The proposed regulation does not require the plan fiduciary to terminate the contract but instead requires the plan fiduciary to determine whether they should continue the contract or arrangement

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Proposed Effective And Applicability Dates

- There is both an effective date and an applicability date
- The proposed rule would be effective 60 calendar days after the date of the publication of the final rule
- It would be applicable to plan years beginning on and after July 1, 2026
- The comment deadline for the proposed rule is April 15, 2026

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Considerations

- The proposed regulations were issued prior to the passage of CAA 2026 (which will be discussed next)
- There are many similarities between the proposed regulations and the CAA 2026
- It is unclear if the DOL will revise these regulations to take into account the CAA 2026, or just push through to finalize these proposed regulations
- Plan sponsors will need to determine who are the “responsible fiduciaries” to review this information, how to read all of the information being disclosed and determine if the compensation is “reasonable”

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CAA 2026 Pharmacy Benefit Management Services Provisions

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Consolidated Appropriations Act, 2026 (CAA 2026)

- First significant federal legislative effort to reform PBMs after years of increasing scrutiny and many failed proposals
- Signed into law on February 3, 2026
- Section 6701 imposes significant PBM reporting requirements
  - Amends ERISA, the Internal Revenue Code (IRC), and the Public Health Service Act (PHSA)
  - Applies to ERISA group health plans and non-ERISA health plans (e.g., governmental plans, church plans)
- Section 6702 amends ERISA prohibited transaction rules
  - Applies to ERISA group health plans

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CAA 2026: PBM Oversight

- These PBM transparency requirements are effective for plan years beginning on or after 30 months following CAA 2026's enactment
  - January 1, 2029 for calendar plan years
- Contract Requirement: Group health plans (GHP), large group health insurance issuers, and PBMs cannot enter into agreements with an Applicable Entity (e.g., drug manufacturer, wholesaler, group purchasing organization, rebate aggregator) unless the Applicable Entity agrees to:
  - Not limit or delay disclosing information to the GHP (self-funded and fully-insured) that prevents the PBM from providing CAA 2026-required reporting
  - Provide PBMs with relevant information necessary to provide the reporting required by the CAA 2026

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CAA 2026: PBM Oversight—Required Reporting

- PBMs providing services on behalf of a GHP or large group health insurance issuer must submit a report to the GHP:
  - At least every 6 months
    - A GHP can request frequency to be no less than quarterly (subject to the same conditions, terms and cost as semiannual reports)
  - In plain language
  - In a machine-readable format (other formats may be required, as determined by HHS, DOL and Treasury)

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Report for self-funded Specified Large Employers and Specified Large Plans
  - "Specified Large Employer" means an employer who establishes/maintains a GHP and who employed an average of at least 100 employees on business days during the preceding calendar year/plan year and who employs at least 1 employee on the first day of the calendar year/plan year
  - "Specified Large Plan" means a GHP established/maintained by an ERISA plan sponsor that has at least 100 participants on business days during the preceding calendar year/plan year (e.g., single employer plans, multiemployer plans)

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Part 1 of report for Specified Large Employers and Specified Large Plans must include a list of drugs for which a claim was filed and detailed cost and dosage information with respect to each drug, including:
  - The contracted compensation paid by the GHP/issuer to the PBM, the contracted compensation paid to the pharmacy by the PBM for each covered drug, and the difference between the two prices ("spread compensation")
  - The type of dispensing channel used to furnish each drug (including retail, mail order, specialty pharmacy)
  - Whether the drug is a brand name or generic, the wholesale acquisition cost (listed as cost per day's supply and cost per dosage unit) on the dispensed date, and the average wholesale price (listed as cost per day's supply and cost per dosage unit)
  - The total amount of out-of-pocket spending by participants (e.g., copays, coinsurance, deductibles)—excludes drugs not covered by plan

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Part 2 of report for Specified Large Employers and Specified Large Plans must include a list of each therapeutic class for which a claim was filed under the plan/issuer, including:
  - Total gross spend before rebates, price concessions, alternate discounts, and net spending after such rebates and discounts
  - Total received or expected in rebates, fees, alternative discounts or other remuneration by PBM for claims related to utilization of drug
  - Average net spending per 30-day supply and per 90-day supply by the plan/issuer among all drugs within the class

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Part 3 of report for Specified Large Employers and Specified Large Plans must include a list of any drug for which the plan's gross spend exceeded $10,000 during the reporting period (or the top 50 drugs in gross spending if the gross spend for fewer than 50 drug exceeded $10,000), including:
  - A list of all other drugs in the same therapeutic class
  - The rationale for the formulary placement (from a list of standard rationales established by HHS, DOL, Treasury)
  - Any change in formulary placement from prior plan year

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Part 4 of report for Specified Large Employers and Specified Large Plans must disclose whether the plan, issuer, or PBM has an affiliated pharmacy or pharmacy under common ownership (e.g., mandatory mail, auto-refill program, copay assistance program), including:
  - Explanation of any benefit design that encourage/require participants to use those affiliated pharmacies
  - Percentage of total prescriptions dispensed by such pharmacies
  - Certain costs for all drugs dispensed by such pharmacies

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Opt-In for Fully-Insured Group Health Plans
  - Although the PBM report for Specified Large Employers and Specified Large Plans applies to self-funded plans, fully-insured group health plans for Specified Large Employers and Specified Large Plans can elect, on an annual basis, to require the PBM to provide the report to the fully-insured plans

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Summary Report for All Group Health Plans
  - A summary document for all GHPs (self-funded and fully-insured, regardless of size) of the information provided to Specified Large Employers and Specified Large Plans that the agencies determine is useful to GHPs for selecting PBM services, such as:
    - Estimated net price to GHP and participants
    - Cost per claim
    - Fee structure or reimbursement model

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CAA 2026: PBM Oversight—Required Reporting, cont'd

- Summary Report for All Group Health Plans—Participant Disclosure
  - A summary document for all GHPs (self-funded and fully-insured, regardless of size) to provide to participants (upon request) with information that the agencies determine is useful for participants to better understand the plan coverage, including:
    - Total net spending by the plan for covered drugs, total received by the plan in rebates/fees/discounts
    - Amounts paid to the plan/issuer for the referral, consideration, and retention of the PBM
    - Designs that encourage/require participants to use the PBM's affiliated pharmacies
  - GHPs must provide an annual notice to participants of the PBM reporting requirement (notice can be included in plan documents provided to participants)

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CAA 2026: PBM Oversight

- Reports to Plan Participants
  - Group health plans (including fully-insured) must provide participants and beneficiaries, upon request, with the PBM summary report and the spread compensation with respect to a claim made by the participant or beneficiary

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CAA 2026: PBM Oversight, cont'd

- Privacy Requirements
  - Reports must be consistent with HITECH and HIPAA privacy rules
  - The PBM must ensure reports contain only summary health information
  - GHPs may only share PBM reports with business associate
  - PBMs may place reasonable restrictions on public disclosure of information

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CAA 2026: PBM Oversight—Enforcement

- HHS, DOL and Treasury have authority to enforce the PBM oversight provisions with respect to GHPs (self-funded and fully-insured) and PBMs providing services on behalf of GHPs
- GHPs, issuers, and PBMs that fail to provide reports (to plans or participants) are subject to civil monetary penalties of $10,000 for each day violation continues
- Issuers, PBMs and third-party administrators that knowingly provides false information are subject to a civil monetary penalty capped at $100,000 for each item of false information
- Agencies may waive penalties for failure to provide reports or grant additional time for compliance for an entity that has made a good-faith effort to comply with requirements

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Section 6072 of CAA 2026—Amends Prohibited Transaction Rule

- 100% Pass-Through Compensation Required. ERISA 408(b)(2)(B) is amended to require PBMs to remit 100% of rebates, fees, alternative discounts, and other remuneration received from any applicable entity related to utilization of drugs under the plan to the plan/issuer—otherwise the agreement is not reasonable
- Effective for PBM contracts that are entered into, renewed, or extended for plan years beginning on or after 30 months after the date of CAA 2026 enactment (August 3, 2028)

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Section 6072 of CAA 2026—Amends Prohibited Transaction Rule, cont'd

- Rebates, fees, alternative discounts and remunerations must be:
  - Remitted on a quarterly basis to the GHP or group health insurance issuer no later than 90 days after the end of each quarter
    - For underpayment of remittance due for a prior quarter, payment must be made as soon as practicable but no later than 90 days after notice of underpayment
  - Returned to the PBM if an audit indicates the amounts are in excess of correct amounts

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Section 6072 of CAA 2026—Amends Prohibited Transaction Rule, cont'd

- Rebate aggregators and group purchasing organizations must remit rebates to PBMs no later than 45 days after the end of each quarter
- TPAs, group health insurance issuers, and PBMs must make rebate contracts with rebate aggregators and drug manufacturers available for audit by the plans
- Responsible plan fiduciary will select auditor for the above requirements

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Section 6072 of CAA 2026—Amends Prohibited Transaction Rule, cont'd

- Current Fee Disclosure Requirement
  - Under ERISA 408(b)(2), "covered service providers" are required to disclose certain information to GHPs about direct and indirect compensation that the providers reasonably expect to receive in connection with plan services
  - Entities that provide brokerage services or consulting to GHPs and expect to receive $1,000 or more in compensation are subject to the disclosure requirement

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Section 6072 of CAA 2026—Amends Prohibited Transaction Rule, cont'd

CAA 2026 Broadens the Scope of Fee Disclosure Requirement

- Effective for contracts entered into, extended, or renewed after February 3, 2026, CAA 2026 expands the type of services provided to an ERISA GHP that would cause an entity to be a "covered service provider" beyond brokerage services and consulting. Accordingly, the fee disclosure requirement applies to virtually all GHP services, including:
  - Plan design, insurance or insurance product selection, recordkeeping, medical management, benefits administration selection, stop-loss insurance, PBM services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third-party administration services, or consulting services related to any such services

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Employer Considerations for CAA 2026 PBM Provisions

- Regulations related to PBM reporting requirements are expected within 18 months
- The PBM transparency requirements will provide employers with a significant amount of information
  - Consider how to understand and leverage the information for PBM contract negotiations and oversight
  - Continue to be diligent with PBM contracts (e.g., definitions, spread pricing, guarantees)
- Prepare for participant notice and disclosure requirements
- Establish procedures for monitoring and auditing rebates, fees, alternative discounts, and other remuneration
- Implement procedure for requesting fee disclosures when engaging with health plan service providers

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Issues Impacting Qualified Plans

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Required Amendment Deadlines

- SECURE Act, §104 of the Miners Act, §§ 2202-2203 of the CARES Act, §302 of the Relief Act, and SECURE 2.0
  - December 31, 2026 for Non-Governmental Qualified Plans
  - December 31, 2028 for Collectively Bargained Plans
  - December 31, 2029 for Governmental Plans
- Required Minimum Distributions Final Regulations
  - December 31, 2027 for most plans

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Required Amendments: CARES Act, Relief Act, Miners Act, SECURE Act, SECURE 2.0

- Required plan amendment deadlines set forth in the Acts
- Extended by subsequent IRS notices, regulations, and annual Required Amendments List

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Bipartisan American Miners Act of 2019 (Miners Act): Reduced Minimum Age for In-Service Distributions for Pension Plans (Optional)

- Enacted December 20, 2019, as part of the Further Consolidated Appropriations Act, 2020
- Lowered the minimum age for in-service distributions to age 59-½ for defined benefit plans, money purchase plans, and governmental 457(b) plans
- Effective for plan years after December 31, 2019
- Plan amendment is required only if implemented

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Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act)

- Enacted December 20, 2019, as part of the Further Consolidated Appropriations Act, 2020
- First major retirement legislation in over a decade
- Modified required minimum distribution (RMD) rules
- Introduced new participant distribution options
- Created long-term part-time employee eligibility requirement
- Laid foundation for later changes under SECURE 2.0

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SECURE Act: Qualified Birth or Adoption Distributions (QBADs) (Optional)

- Added a new in-service distribution for qualified child births and adoptions of up to $5,000 from an eligible plan (e.g., 401(k), 401(a) (except defined benefit plans)), and 403(a) plans) (in the aggregate)
  - Excepted from 10% tax for early withdrawals
- If added, must allow recontribution of a QBAD within 3 years after distribution if the recontributing individual received the QBAD from the plan and the individual is eligible to make a rollover to the plan when recontributions are made
- Effective for distributions on or after January 1, 2020
- Plan amendment is required only if implemented

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SECURE Act: Auto-Enrollment Safe Harbor Cap Increase (Optional)

- Raises the cap for the Qualified Automatic Contribution Arrangement (QACA) salary deferral safe harbor from 10% to 15% of eligible compensation after the participant's initial year
- Effective for plan years beginning after December 31, 2019
- Plan amendment is required only if implemented

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SECURE Act: Long-Term Part-Time Eligibility (Mandatory)

- Requires 401(k) plans (and 403(b) plans effective 2025) to allow long-term, part-time (LTPT) employees to make elective deferrals once they have reached age 21 and have earned at least 500 hours of service in two consecutive 12-month periods (three consecutive 12-month periods for plan years beginning before 2025)
  - SECURE 2.0 shortened the required number of consecutive 12-month periods from three to two and extended the LTPT rules to 403(b) plans
- Effective for plan years beginning after December 31, 2020, with LTPT employees first becoming eligible under the 3-year rule in 2024 plan years, and under the 2-year rule in 2025 plan years

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Coronavirus Aid, Relief, and Economic Security (CARES) Act

- Enacted March 27, 2020, in response to COVID-19 pandemic
- Included temporary retirement plan relief measures
- Designed to provide liquidity and flexibility for participants
- Suspended certain retirement plan distribution restrictions and RMD requirements
- Most provisions were optional and time-limited
- Plan amendment is required if relief was implemented

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CARES Act: Coronavirus-Related Distributions (Optional)

- Permitted eligible plans (e.g., 401(k), 403(b), and governmental 457(b) plans) to allow for Coronavirus-Related Distributions of up to $100,000 (in the aggregate) to qualified individuals affected by COVID-19
  - 10% early distribution penalty waived
  - Income includible ratably over 3 years (unless elected otherwise)
  - 3-year recontribution right to an eligible retirement plan
- Available for distributions made January 1, 2020 through December 31, 2020
- Plan amendment is required only if relief was implemented

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CARES Act: Plan Loan Relief (Optional)

- Increased maximum plan loan limits for eligible plans (e.g., 401(k) and 403(b) plans) for qualified individuals affected by COVID-19
- Loans from an eligible plan to a qualified individual on or after March 27, 2020, and before September 23, 2020, may be made up to the lesser of:
  - Up to $100,000, or
  - 100% of vested account balance
- Permitted up to one year suspension of loan repayments due between March 27, 2020, and December 31, 2020
- Plan amendment is required only if relief was implemented

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CARES Act: 2020 RMD Waiver (Optional)

- Waived required minimum distributions (RMDs) during 2020 for defined contribution plans and provided special rollover relief
- Effective for 2020 calendar year
- Plan amendment is required only if waiver was implemented
  - IRS Notice 2020-51 provided sample plan amendment

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Taxpayer Certainty and Disaster Tax Relief Act of 2020 (Relief Act)

- Enacted December 27, 2020, as part of the Consolidated Appropriations Act, 2021
- Included qualified disaster-related relief provisions similar to relief Congress utilized in the past to respond to wildfires, hurricanes, and other natural disasters
- Designed to address natural disasters that occurred coincident with the COVID-19 pandemic by relaxing retirement plan distribution rules to give participants more access to their funds and to provide penalty relief for distributions taken during such a disaster
- Provisions were optional and time-limited
- Plan amendment is required if relief was implemented

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Relief Act: Qualified Disaster Distributions (Optional)

- Permitted eligible plans (e.g., 401(k), 403(b), and governmental 457(b) plans) to allow for Qualified Disaster Distributions of up to $100,000 (in the aggregate) to qualified individuals
  - 10% early distribution penalty waived
  - Income includible ratably over 3 years (unless elected otherwise)
  - 3-year recontribution right to an eligible retirement plan
- Distribution must be made to a qualified individual on or after the first day of the incident period of a “Qualified Disaster” and before June 25, 2021
- Plan amendment is required only if relief was implemented

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Relief Act: Disaster-Related Plan Loans (Optional)

- Increased maximum plan loan limits for eligible plans (e.g., 401(k), 403(b), and governmental 457(b) plans) for qualified individuals
- Loans from a qualified plan to a qualified individual on or after the first day of the incident period of a "Qualified Disaster" and before June 25, 2021, may be made up to the lesser of:
  - Up to $100,000, or
  - 100% of vested account balance
- Permitted suspension of loan repayments for a period of up to one year or up to June 25, 2021, if longer
- Plan amendment is required only if relief was implemented

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Relief Act: Return of Withdrawals for Home Purchase or Construction (Optional)

- Permitted eligible plans to allow participants to recontribute any hardship distributions initially taken to purchase or construct a principal residence in a "Qualified Disaster Area"
- The hardship distribution must have been received no more than 180 days before and within 30 days after the Qualified Disaster incident and the repayment must be made no later than June 25, 2021
- Plan amendment is required only if relief was implemented

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Required Minimum Distribution (RMD) Final & Proposed Regulations

- Final Regulations and Proposed Regulations issued under Code § 401(a)(9) on September 17, 2024
- Implemented statutory changes enacted under SECURE Act and SECURE 2.0
- Provided guidance on lifetime and post-death RMD rules
- Clarified application of the 10-year rule for beneficiaries
- Final Regulations included in IRS Required Amendments List for 2025 - December 31, 2027, deadline for most plans
- Proposed Regulations to be included in future Required Amendments List

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RMD Final Regulations

- Reflect statutory increase in RMD age under the SECURE Act and SECURE 2.0
  - Born before July 1, 1949: Age 70½
  - Born July 1, 1949, through December 31, 1950: Age 72
  - Born January 1, 1951, through December 31, 1959: Age 73
  - Born on or after January 1, 1960: Age 75
- Applies to defined contribution and defined benefit plans
- Plans can require an earlier, mandatory benefit commencement date

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RMD Final Regulations, cont'd

- 10-year rule for designated beneficiaries
  - Applies to most non-EDB designated beneficiaries
  - If participant dies after their Required Beginning Date (RBD), annual RMDs required in years 1-9
  - Full distribution required by end of 10th year
- Eligible Designated Beneficiaries (EDBs)
  - May receive life expectancy payments
  - Upon EDB's death (or minor child reaching age of majority), 10-year rule applies
- Spousal election to be treated as participant

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Setting Every Community Up for Retirement Enhancement Act of 2022 (SECURE 2.0 Act)

- SECURE 2.0 was signed into law on December 29, 2022, as part of the Consolidated Appropriations Act of 2023
- Builds upon the retirement improvements within the SECURE Act
- Aims to expand retirement coverage and increase retirement savings
- Includes provisions intended to simplify plan rules and generate revenue for the U.S. Department of the Treasury
- Contains more than 90 substantive changes to retirement plan law
- Extensive guidance has been issued on SECURE 2.0 since its enactment

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Higher Catch-Up Contribution Limits (Optional)

- Secure 2.0 introduced enhanced catch-up limits known as “super catch-up” contributions
- 401(k), 403(b), and governmental 457(b) plans have the option to allow employees who attain age 60-63 during a calendar year to make higher catch-up contributions
- For 2026:
  - Increased catch-up limit is $11,250 (indexed for inflation)
  - Total possible contribution is $35,750 ($24,500 regular + $11,250 super catch-up)
- Final Regulations clarified that if one employer in a controlled group adopts the higher catch-up limit, all employers in the same controlled group must also adopt higher-catch up limit
- Effective Date:
  - Taxable years beginning after December 31, 2024

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Increased Dollar Limit for Mandatory Distributions (Optional)

- The involuntary cash-out limit is increased to $7,000 from $5,000
- This change applies to both DC and DB plans
- If the balance is over $1,000, the amount must still be rolled over to an IRA if the participant does not consent to the distribution
- Effective Date:
  - Distributions made after December 31, 2023

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Rules for Qualified Federally Declared Disasters (Optional)

- SECURE 2.0 codifies tax and qualification relief for distributions made as a result of federally-declared disasters
- A qualified retirement plan, 403(b) plan, and governmental 457(b) plan may permit "affected" participants living in a federal disaster area to make a withdrawal of up to $22,000 within 180 days after the disaster, without being subject to the10% early withdrawal penalty (applicable period will not end earlier than June 27, 2023)
- Amounts can be taken into income over three years and may be repaid to the plan (in whole or in part) within three years (amounts repaid treated as a timely rollover contribution)

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Rules for Qualified Federally Declared Disasters (Optional) (cont'd)

- Loan Limit Increases: Plans may increase the maximum loan amount to the lesser of $100,000 or 100% of a participant's vested account balance and extend the repayment period for up to one year (with respect to payments due within 180 days of the disaster)
- Home Purchase Relief: Hardship distributions used to purchase a home may be recontributed to a plan if those funds were to be used to purchase a home in an area that became a disaster area before the funds were used. Unused withdrawals to purchase a home may be rolled over
- Effective Date:
  - Disasters occurring on or after January 26, 2021

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Optional Treatment of Employer Matching or Nonelective Contributions as Roth Contributions (Optional)

- 401(a), 403(b), and governmental 457(b) plans may permit certain employer matching and non-elective contributions to be designated as Roth contributions
- Student loan matching contributions (discussed further) may also be designated as Roth contributions
- Only employees fully vested in matching contributions or nonelective contributions can make a Roth designation for those contributions
- IRS Notice 2024-2 answers some key implementation questions
- Effective Date:
  - December 29, 2022

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Withdrawals for Certain Emergency Expenses (Optional)

- A qualified retirement plan, 403(b) plan, and governmental 457(b) plan may allow for one penalty-free withdrawal in any calendar year of up to $1,000 per year for "unforeseeable or immediate financial needs relating to personal or family emergency expenses"
- Withdrawal must be repaid within three years to receive rollover treatment
- Only one withdrawal per three-year repayment period is permitted, if the first withdrawal has not yet been repaid
- Plans may rely on a participant's self-certification
- Effective Date:
  - Plan years beginning after December 31, 2023

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Penalty-Free Withdrawals for Cases of Domestic Abuse (Optional)

- A DC plan or governmental plan (unless subject to the QJSA requirements) may permit in-service distributions to a victim of domestic abuse by a spouse or domestic partner
- Domestic Abuse: Physical, psychological, sexual, emotional, or economic abuse, including efforts to control, isolate, humiliate, or intimidate the victim, or to undermine the victim's ability to reason independently, including by means of abuse of the victim's child or another family member living in the household
- The participant may self-certify the domestic abuse

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Penalty-Free Withdrawals for Cases of Domestic Abuse (Optional), cont'd

- The distribution can be made within one year after the occurrence of the abuse and the amount may not exceed the lesser of $10,000 (indexed after 2024) or 50% of the participant's vested account balance
- Amount withdrawn deemed to meet distribution rules and will not be subject to the 10% early withdrawal penalty
- Repayment Option: Within 3 years and will be given rollover treatment (refund on taxes paid)
- Effective Date:
  - Plan years beginning after December 31, 2023

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Treatment of Student Loan Payments as Elective Deferrals for Purposes of Matching Contributions (Optional)

- Employers are permitted to make matching contributions under a 401(k), 403(b), or governmental plan or a SIMPLE IRA with respect to "qualified student loan payments" as long as certain requirements are met
- The term "qualified student loan payment" means a payment made by an employee in repayment of a qualified education loan (as defined in the Code) incurred by the employee to pay qualified higher education expenses (A plan may treat a qualified student loan payment as an elective deferral for purposes of the matching contribution requirements under the safe harbor plan requirements.)

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Treatment of Student Loan Payments as Elective Deferrals for Purposes of Matching Contributions (Optional), cont'd

- Employers are permitted to apply the ADP test separately to employees who receive matching contributions on account of qualified student loan payments
- Employers may reasonably rely on employee certifications of loan payments made, without requiring any supporting verification
- IRS Notice 2024-63 includes an overview of this provision and provides guidance on employee certifications, reasonable procedures to implement this feature, ADP testing and miscellaneous issues
- Effective Date:
  - Plan years beginning after December 31, 2023

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Terminal Illness Withdrawals (Optional)

- Distributions from a DB or DC plan to a participant who is otherwise eligible for a distribution, and who has been determined by a physician to have an illness reasonably expected to result in death within 84 months, will not be subject to the 10% penalty on early distributions
- IRS Notice 2024-2 provides guidance on terminally ill individual distributions
- An employee must furnish a physician's certification, but not underlying documentation of medical condition
- Effective Date:
  - Distributions made after December 29, 2022

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Emergency Savings Account Linked to Individual Account Plans (Optional)

- Employers have the option to offer emergency savings accounts that permit non-highly compensated employees to make after-tax contributions to a special savings account within the plan. (Employers may also automatically enroll such employees in the program)
- Treated as a type of designated Roth account
- Eligible employees may defer up to 3% of compensation, up to a total contribution of $2,500 (adjusted for inflation after 2024)
- An employee's contributions to the emergency savings account must be eligible for matching contributions at the same matching rate established under the plan for elective deferrals
- Employees may take at least one tax-free, penalty-free distribution from per calendar month
- IRS Notice 2024-22 clarifies anti-abuse rules; DOL FAQs address applicable ERISA requirements
- Effective Date: Plan years beginning after December 31, 2023

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Reliance on Employee Certification of Hardship (Optional)

- SECURE 2.0 codified the right of a plan administrator of a 401(k), 403(b) or governmental 457(b) plan to accept and rely on an employee's certification that:
  - an amount requested for a hardship withdrawal is on account of financial need
  - the amount requested is not in excess of that need; and
  - that the employee has no reasonable available means to satisfy the need
- Effective Date:
  - Plan years beginning after December 31, 2022

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Military Spouse Retirement Plan Eligibility Credit for Employers (Optional)

- Employers with up to 100 employees are eligible for a tax credit if they make military spouses eligible for their defined contribution plans within two months of their hiring date, ensure that each military spouse is 100% vested in all employer contributions, and guarantee that every military spouse is eligible for any matching or nonelective contribution that they otherwise would only have qualified for at two years of service
- The tax credit is equal to $200 per military spouse plus up to $300 in employer contributions per individual for up to three years
- Effective Date: Taxable years beginning after December 29, 2022

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Small Immediate Financial Incentives for Contributing to a Plan (Optional)

- SECURE 2.0 permits employers to offer *de minimis* financial incentives to employees who make elective deferrals to a 401(k) or 403(b) plan
- IRS Notice 2022-4:
  - Limits the amount of a *de minimis* financial incentive to $250
  - Clarifies that incentive may only be provided to those who are not already participating in the plan
  - The incentive can be in the form of installments
- Such incentives will be exempt from the contingent benefit rule and, therefore, will not trigger the prohibited transaction rules under the Code or ERISA, provided that the incentives are not paid with plan assets
- Effective Date:
  - Plan years beginning after December 31, 2022

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Requirement for Automatic Enrollment in New Plans (Mandatory)

- New 401(k) and 403(b) plans adopted after December 29, 2022, are required to include an eligible automatic contribution arrangement (EACA) with:
  - a default deferral rate of between 3%, and 10%; and
  - an automatic escalation of 1% per year up to at least 10%, but not more than 15%, and
  - a 90-day permissive withdrawal feature
- Exceptions: Governmental and church plans, SIMPLE plans, businesses with 10 or fewer employees, and employers that have been in business for less than three years are exempt from this provision
- Proposed Regulations issued in January 2025 and would apply to plan years that begin more than 6 months after the date final regulations under Code Section 414A are issued
  - Until then, plans must comply with a reasonable, good faith interpretation of the law
- Effective Date: Plan years beginning after December 31, 2024

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Other SECURE 2.0 Provisions Effective in 2026

- Requirement to Provide Paper Statements in Certain Cases (mandatory)
  - DC plans must provide a paper benefit statement at least once annually and DB plans must provide a paper benefit statement at least once every three years, unless the plans follow the 2002 electronic disclosure safe harbor rules released by the DOL, or the plan participant or beneficiary requests that such statements be provided electronically
  - Proposed DOL guidance was issued on February 24, 2026
  - Effective Date: Plan years beginning after December 31, 2025
- Correction of Mortality Tables (mandatory)
  - For purposes of the minimum funding rules, a pension plan may not assume, beyond the plan's valuation date, future mortality improvements at any age greater than 0.78%
  - Treasury issued final regulations in October 2023 to reflect this requirement
  - Effective Date: December 29, 2022

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Amendment Deadlines Pending Guidance

- Roth Catch-Up Mandate for High Earners Contributions (mandatory)
  - Beginning January 1, 2026, catch-up contributions for high earners must be made on a Roth basis
  - Operationally complex provision
  - Final regulations were issued on September 15, 2025, and generally apply to catch-up contributions made in tax years beginning after December 31, 2026
  - Expected to be on 2027 Required Amendments List, with a December 31, 2029 deadline
- SECURE 2.0 RMD provisions covered by Proposed Regulations
  - Will be included in a future Required Amendments List

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IRS Priority Guidance

- Released annually by the Treasury Department's Office of Tax Policy and IRS
- Used to identify and prioritize tax issues that should be addressed through regulations, revenue procedures, revenue rulings, notices, and other published administrative guidance
- Released September 30, 2025, for the period of July 1, 2025 through June 30, 2026

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IRS Priority Guidance for 2025-2026: SECURE 2.0

- IRS Employee Plans guidance, including updated Employee Plans Compliance Resolution System, to reflect SECURE 2.0 provisions
- Guidance implementing SECURE 2.0 including:
  - Saver's match, qualified student loan matching contributions, long-term part-time employee eligibility, pension-linked emergency savings accounts, rollover rules, qualified long-term care distribution and repayment under Code § 72(t) of certain distributions added by SECURE 2.0

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IRS Priority Guidance for 2025-2026

- Final regulations related to Required Minimum Distributions (prior regulations and a proposed rule were published 7/19/2024)
- Final regulations and guidance on unified plan rule for Multiple Employer Plans (proposed rule was published 3/28/2022)
- Final regulations on automatic enrollment requirements (proposed rule was published 1/10/2025)
- Final regulations on updates to catch-up contribution rules (final rule was published on 9/16/2025)
- Guidance on uncashed checks (released as Rev. Rul. 2025-15 on 7/16/2025)

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IRS Priority Guidance for 2025-2026: One, Big, Beautiful Bill Act

- Guidance regarding new tax advantaged savings accounts for children under age 18 called “Trump Accounts”

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Upcoming Legislation: What could be in a SECURE 3.0?

- Rothification of contributions
- Enhanced automatic enrollment
- Expanded catch-up contributions
- Increased access for part-time and gig workers
- Promotion of lifetime income options
- Streamlining of rollovers
- Permit 403(b) plans to invest in collective investment trusts

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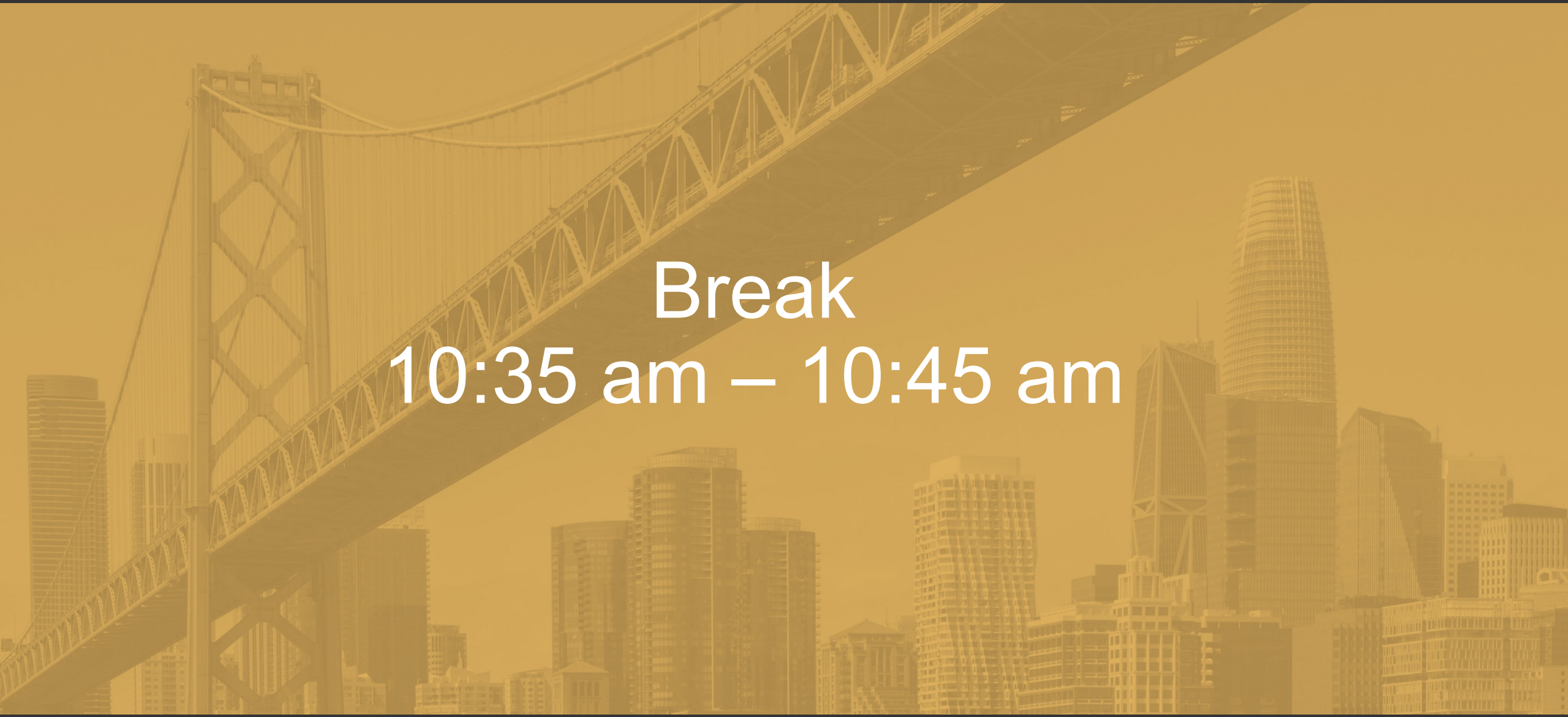

Break
10:35 am – 10:45 am

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Litigation Lessons and Minimizing Risks

Brian Murray

Catherine Reagan

Kim Ong

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Pension Risk Transfer (PRT) Litigation

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Pension Risk Transfer Overview

- In a pension risk transfer ("PRT"), a plan sponsor transfers all or part of its benefit obligations under a defined benefit plan by using plan assets to pay a premium to purchase irrevocable annuities from one or more insurance companies
- Insurer assumes the responsibility of future benefit payments to employees and retirees covered by PRT
- Common annuity providers include Prudential, New York Life Insurance Company, and MetLife

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Pension Risk Transfer Overview, cont'd

- LIMRA survey reports that PRT market has increased with total PRT premiums growing to $51.8 billion in 2024, up 14% from 2023. New cases slowed in 2025 as early defense motions to dismiss granted
- In a 2024 poll conducted by MetLife of 250 defined benefit plans with de-risking goals, 9 in 10 companies reported that they planned to divest all plan liabilities
- Why do a PRT?
- Transfer of longevity and market risk
- Reduced PBGC premiums
- Get out of the plan administration business (for full terminations)

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Anatomy of Pension Risk Transfers

- Make decision to do a PRT and amend the plan (settlor action)
- Implement the decision to do a PRT (fiduciary actions). Typically involves:
  - Selecting service providers (consultant, actuary, lawyer)
  - In some cases, selecting an independent fiduciary
  - Issuing request for proposal (“RFP”)
  - Analyzing RFP responses
  - Selecting insurer
  - Paying premium

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Anatomy of Pension Risk Transfers, cont'd

- Reviewing and negotiating Commitment Agreement and Group Annuity Contract
- Communicating with participants
- In the case of a full termination, submitting required filings to PBGC
- Partial transfer typically takes 3-4 months; full termination, 12-18 months

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DOL Interpretive Bulletin 95-1

- IB 95-1 (29 CFR § 2509.95-1) provides guidance as to fiduciary's selection of an annuity provider in connection with a PRT
- Fiduciaries must take steps to obtain "the safest annuity available"
- Fiduciaries should "evaluate the insurer's claims paying ability and creditworthiness"
- Fiduciaries must "obtain the advice of a qualified, independent expert" if they do not possess the expertise to properly evaluate these factors

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DOL Interpretive Bulletin 95-1, cont'd

- Fiduciaries should "evaluate the insurer's claims paying ability and creditworthiness" by considering six factors:
  - the annuity provider's investment portfolio quality and diversification
  - "the size of the insurer relative to the proposed contract"
  - "the level of the insurer's capital and surplus"
  - the insurer's exposure to liability
  - the structure of the annuity contract and guarantees supporting them
  - the availability of additional protection through state guaranty associations

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Pension Risk Transfer Litigation

- Approximately 13 cases filed to date
- Most cases have centered on annuity provider Athene Holding Ltd., with two involving Prudential
- Allegations include
  - Breach of duties of prudence and/or loyalty in selecting service provider
  - Engagement in prohibited transactions
  - Failure to monitor independent fiduciary

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Pension Risk Transfer Litigation, cont'd

- Plaintiffs in these cases raise concerns about:
  - Private equity ownership and control over insurer
  - Use of captive, offshore reinsurers
  - Allegedly "risky" investment philosophies
  - Loss of PBGC and ERISA protections

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Pension Risk Transfer Litigation, cont'd

- Defendants' arguments on motions to dismiss:
  - Plaintiffs lack Article III standing—no damages, participants are receiving all benefits; future harm is speculative; claims are unripe (*Thole v. U.S. Bank N.A.*)
  - Plaintiffs fail to state a claim under ERISA—no allegation of improper process or that independent fiduciary benefited from selection of insurer; no harm or causation alleged
  - Prohibited transaction claims fail because Athene is not a party-in-interest

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Pension Risk Transfer Litigation, cont'd

- *Konya v. Lockheed Martin Corp.*, No. 8:24-cv-00750, (D. Md. Mar. 28, 2025) (**MTD denied; 4th Circuit interlocutory appeal pending, with amicus brief from DOL supporting Lockheed**)
- *Schloss v. AT&T Inc. and State Street Global Advisors Trust Co. and Piercy v. AT&T Inc. and State Street Global Advisors Trust Co*, No. 1:24-cv-10608 (D. Mass.) (**consolidated, MTD amended complaint is pending**)
- *Camire v. Alcoa USA Corp.*, No. 1:24-cv-01062 (D.D.C. Mar. 28, 2025) (**MTD granted on standing grounds**)
- *Bueno v. General Electric Co.*, No. 1:24-cv-00822 (N.D.N.Y.) (**amended complaint dismissed without prejudice; plaintiffs lacked standing because no imminent risk of harm or concrete injury from loss of PBGC protections**)
- *Schoen v. ATI, Inc. and Souza v. ATI, Inc.*, No. 2:24-cv-01109 (W.D. Pa.) (**consolidated, and magistrate recommended granting MTD; final ruling pending**)
- *Doherty v. Bristol-Myers Squibb Co. and State Street Global Advisors Trust Co. and Noel v. Bristol-Myers Squibb Company*, No. 1:24-cv-06628 (S.D.N.Y.) (**consolidated, and MTD denied; 2nd Circuit interlocutory appeal petition pending**)
- *Dempsey v. Verizon*, No. 1:24-cv-10004 (S.D.N.Y.) (**MTD granted with prejudice; no standing**)

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Konya v. Lockheed Martin Corp.

- Alleges Lockheed Martin Corporation (LMC) is a fiduciary under ERISA as to the PRT because selecting an annuity provider involves discretionary authority over management of a plan and its assets
- Alleges that LMC made the fiduciary decision to engage in a PRT to Athene Annuity and Life Company that is a subsidiary of Athene Holding, Ltd.
- Athene is a leading player in the PRT market, having completed 45 transactions totaling $50.5 billion and over 550,000 plan participants
- Alleges that the PRT to Athene was a breach of ERISA fiduciary duty because Athene is a “private-equity controlled insurance company with a highly risky offshore structure”
- Alleges loss of PBGC protections after transfer

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Konya v. Lockheed Martin Corp., cont'd

- Alleges LMC transferred about $9 billion in pension obligations for ~31,000 retirees
- Alleges that LMC received an economic benefit from the selection of Athene in the form of reduced premium payments relative to what it would have paid to an established and reputable insurance provider like Prudential or New York Life
- Alleges that LMC selected Athene to save the company money and enhance corporate profits
- Claims include breach of fiduciary duty of loyalty and prudence, failure to monitor, and prohibited transactions
- Requests relief including disgorgement by LMC of profits/cost and the posting of security to assure receipt by the participants of their full retirement benefits, plus prejudgment interest

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Konya v. Lockheed Martin Corp., cont'd

- Court Denied Motion to Dismiss, found plaintiffs have standing
- Distinguished *Thole*; in that case, the Supreme Court noted underfunding does not create a substantial increased risk both the plan and employer will fail
- District court recognized standing a close call, but found plaintiffs' allegations that plaintiffs' pensions are at substantial risk if Athene fails because they are no longer backed by the employer or the PBGC were sufficient
- Statutory standing under ERISA 502(a)(9), 29 U.S.C. § 1132(a)(9), to seek posting of security to assure receipt of payments
- For the prohibited transaction claims:
  - Court agreed with Lockheed that Athene was not a party in interest
  - However, court found Plaintiff plausibly alleged that Lockheed used plan assets for its own interest by selecting Athene, if as alleged, that decision placed Lockheed's interests in lower premiums above participants' interests

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Konya v. Lockheed Martin Corp., cont'd

- Currently on interlocutory appeal at the Fourth Circuit
- DOL filed amicus brief urging the court to dismiss the claims for lack of standing
- The DOL argued that vexatious litigation could discourage employers from offering defined benefit plans. Also, argued that PRTs have a 30-year track record without a single default, and that the transfer process "changes nothing material" for beneficiaries
- Former DOL officials subsequently filed amicus brief challenging current DOL's stance and supporting plaintiffs
- State AG Support: Led by Iowa's Attorney General and joined by nine other states, these briefs contend that challenging the choice of a state-regulated insurer (like Athene) is an attack on the efficacy of state insurance laws

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Camire v. Alcoa USA Corp.

- *In Camire v. Alcoa USA Corp*., No. 1:24-cv-01062 (D.D.C. March 28, 2025), the Washington D.C. District court accepted the plaintiffs' assertion that the backing of a state guaranty association was not as robust as that provided by the PBGC, yet still found that the risk of harm alleged by the plaintiffs was neither sufficiently "imminent" nor "certainly impending"
- Court granted Defendants' motion to dismiss on standing grounds
- Because the defendants had moved under both Fed. R. Civ. P. 12(b)(1) (arguing that plaintiffs lacked Article III standing and thus the court lacked federal subject matter jurisdiction), and 12(b)(6), the *Alcoa* court began with the 12(b)(1) motion, and determined that because there was no subject matter jurisdiction, it could not address the defendants' Rule 12(b)(6) arguments that the plaintiffs also failed to state a claim upon which relief may be granted

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PRT – Best Practices

- Documenting the “Prudent Process”: Emphasize thorough vetting of insurer capital levels, investment diversification, and state guaranty protections
- The role of independent fiduciaries as a defensive layer in the selection process
- Separation of settlor v. fiduciary decisions/actions
- Participant communications

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Prohibited Transactions

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Prohibited Transactions

- Prohibit ERISA plan fiduciaries from certain transactions including ""furnishing of goods, services, or facilities" between a plan and a "party in interest. ERISA § 406(a)-(b)
- A "party in interest" of an employee benefit plan includes a plan fiduciary as well as any "person providing services to such plan" ERISA § 3(14)
- Exemptions under ERISA § 408(b)(2)
  - Arrangement is reasonable
  - Services are necessary for operation of the plan; and
  - Plan pays no more than reasonable compensation

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Types of Cases Prohibited Transaction Claims Arise

- ESOP Transaction Cases
  - *Henry on behalf of BSC Ventures ESOP v. Wilmington Trust NA,* 72 F.4th 499 (3d Cir. 2023)
- Excessive Fee Cases
  - *Bugielski v. AT&T Services, Inc.*, 76 F.4th 894 (9th Cir. 2023)
- Forfeiture Cases
  - *Hutchins v. HP Inc.*, 737 F. Supp. 3d 851 (N.D. Cal. 2024)
- Pension Risk Transfer Cases

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Cunningham v. Cornell University, 604 U.S. 693 (2025)

- **Facts:**
  - Participants sued fiduciaries and alleged prohibited transactions under ERISA §406(a)
  - Claimed plan paid recordkeeping and investment fees to service providers
  - No allegations in the complaint that fees were unreasonable or excessive
- **Issue:** Raised issue of whether plaintiff had to plead that the transaction did not qualify for an exemption under ERISA § 408
- **Holding:** Plaintiff only needs to plausibly allege prohibited transactions under ERISA §406(a), they do not need to plead facts to anticipate an exemption under ERISA §408
- **Effect:** This ruling may make it easier for plaintiffs to get past the motion to dismiss stage in litigation for prohibited transaction claims

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Excessive Fee Cases Post Cornell

- ***Collins v. Ne. Grocery, Inc.*, 2025 WL 2383710 (2d Cir. Aug. 18, 2025)**
  - Remanded back to district court for reconsideration based on *Cornell*
- ***Fleming v. Kellogg Company*, 2025 WL 4053174 (W.D. Mich. Dec. 8, 2025)**
  - Dismissed prohibited transaction claim
- ***Peeler v. Bayada Home Healthcare*, 2026 WL 208630 (W.D.N.C. Jan. 27, 2026)**
  - Dismissed prohibited transaction claim

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Forfeiture Cases Post Cornell

- ***Gardner-Keegan v. W.W. Grainger, Inc., 2026 WL 194772 (N.D. Ill. Jan. 26, 2026)***
  - Dismissed, use of forfeitures not a prohibited transaction
- ***Becerra v. Bank of America, 2025 WL 3032922 (W.D.N.C. Aug. 12, 2025)***
  - Allowing case to proceed to discovery

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Pension Risk Transfer Cases Post Cornell

- ***Doherty v. Bristol-Myers Squibb*, 2025 WL 2774406 (S.D.N.Y. Sept. 29, 2025)**
  - Allowed some prohibited transaction claims to continue.
- ***Dempsey v. Verizon Commns*, 2026 WL 72197 (S.D.N.Y. Jan. 8, 2026)**
  - Dismissed prohibited transaction claims
- ***Piercy v. AT&T Inc.*, 2025 WL 2505660 (D. Mass. Aug. 29, 2025)**
  - Dismissed prohibited transaction claims

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Practice Pointers

- Effect on pleading standards for prohibited transaction claims
- Effect on litigation of prohibited transaction claims
- Highlights the Importance of the RFP Process
- Highlights the Importance of Documenting Process

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Grab Bag of Day-to-Day ERISA Issues

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Committee Governance & Process Issues

- Best practices:
  - Formal committee charters defining authority or responsibilities
  - Regular meetings
  - Fiduciary training
  - Keep regular minutes
- Courts focus on the fiduciary process
- Strong governance and a robust process is one of the most effective risk mitigators

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Fiduciary Exception to Attorney—Client Privilege

- Legal advice regarding plan administration may be discoverable during litigation
- Applies to:
  - Benefit determinations
  - Interpretation of plan terms
  - Fiduciary decision-making
- Does not apply to:
  - Settlor functions (such as plan design or amendments)
  - Personal defense
- Takeaway:
  - Assume communications may later be discovered in litigation
  - Structure communications thoughtfully
  - Involve counsel early when disputes arise

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Artificial Intelligence in Benefits Administration & Claims

- Growing use of artificial intelligence ("AI") to:
  - Automate claims review and benefit determinations
  - Perform AI-assisted eligibility verification
  - Serve as a participant chat tool
  - Generate draft denial letters and participant communications
  - Flag potential fraud, waste, and abuse

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Artificial Intelligence in Benefits Administration & Claims, cont'd

- *Kisting-Leung v. Cigna Corp.*, 780 F. Supp. 3d 985 (E.D. Cal. 2025)
  - Plaintiffs allege:
    - Cigna developed and used an internal algorithm called PxDx
    - The system allowed doctors to deny claims in large batches at a time
    - The algorithm applied pre-set criteria to determine medical necessity
    - Physicians spent an average of 1.2 seconds per claim and did not open individual patient files prior to issuing claim denials
  - Court held:
    - Plaintiffs lacked standing to pursue AI-based fiduciary claims where their benefit denials were not processed through the challenged PxDx system, because the alleged injury was not fairly traceable to the AI review process
    - Plaintiffs must show a causal link between the benefit denial and the use of AI to have standing
    - Plaintiffs failed to show that their claims were actually processed through the AI system

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ERISA § 104(b)(4) Document Requests

- ERISA § 104(b)(4), 29 U.S.C. § 1024(b)(4)
  - The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary . . . plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated
- ERISA § 502(c)(1), 29 U.S.C. § 1132(c)(1)
  - Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of [§ 1166, § 1021(e)(1), § 1021(f), § 1025(a), or § 1032(a) of this title] with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required . . . to furnish . . . by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $[110] a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper
  - Increased daily penalty from $100 to $110. 29 C.F.R. 2575.502c-1

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Executive Compensation: Recent Trends and Hot Topics

Scott E. Galbreath, J.D., LL.M. (Tax)

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Agenda

- Trends in Plan Design
- Amendment Deadline for 457(b) Plans of Tax-Exempt Organizations
- 1 BBB Changes to Qualified Small Business Stock exclusion
- Litigation over Financial Advisor Deferred Compensation

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Trends in Plan Design

- Highlights from 3 different studies:
- 2024 Newport/Plan Sponsor NQDC Trends Biannual Survey (NP)
- Plan Sponsor Council of America 2025 NQDC Plan Annual Survey (PS)
- 2025 Goldman Sachs Biennial Executive Benefits Trends Report (GS)

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Trends in Plan Design: Growth

- NP-More small and mid-sized businesses are integrating NQDC plans
  - Attracting & Retaining talent is still #1 goal
- PS-70% of eligible executives participate
  - 86% ERs cite maintaining competitive edge as top reason
- GS-Significant increase in companies adding benefits in 2025
  - 24% added new
  - 20% responding said considering adding new benefits in next 2 years
    - Financial counseling 27%
    - Personal security 15%
- Executive security benefits increased since 2023

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Trends in Plan Design: Funding

- NP-91% use a Rabbi Trust to set aside assets
- PS-2/3 set aside assets with more than 90% using Rabbi Trust
- NP-79% have a voluntary deferral plan, 43% ER contribution only
- PS-80% have ER contributions
- NP-Significant # of ERs “use/track” the 414(q) HCE definition as threshold for eligibility?
- Investments
  - NP-56% use the same options as under the qualified plan
  - PS-40% use same investments as qualified plans

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Trends in Plan Design: Distributions

- NP-Over 70% allow distributions on termination, retirement, and death
  - Only 9% on disability
  - Accelerated vesting: 70% on death, 56% on disability, 35% on CIC
- PS-Almost 75% have distributions at separation from service
  - Nearly 2/3 permit in-service at specified date

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What Do Trends Tell Us?

- Executive Compensation is a very important tool for attracting and retaining talent
  - It is growing and will continue to grow
  - New benefits will continue to be added
- Most ERs use Rabbi Trusts to help secure benefit for Execs
- Many use same investments as qualified plan
- Be careful about the 414(q) definition

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457(b) Plan Amendments

- Sponsored by tax exempt organizations
- For SECURE and SECURE 2.0 Acts Plan Amendments:
  - Changes in ages for RMDs
  - Optional increase of small account amount
  - Anti-stretch rules on beneficiaries
- Deadline extended to 12/31/25 by SECURE 2.0 legislation
- IRS Notice 2024-02 extended to 12/31/26
  - But excluded EO 457(b) plans which remained 12/31/25
- Missing deadline might not make it a 457(f) plan

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Changes to Qualified Small Business Stock

- 1 BBB made significant changes for stock issued on or after 7/4/25
- Before, to qualify as a small business had to be:
  - U.S. C corporation
  - With aggregate gross assets before and after the issuance of the QSBS of no more than $50M
  - At least 80% of assets actively used in a qualified trade or business that's not:
    - Hotel, restaurant, or farming;
    - Accounting, engineering, consulting, financial services, brokerage services;
    - Banking, insurance, financing, leasing, investing, or similar business;
    - Business relying on employee/owner reputation;
    - Mining, oil, or gas producer
- If held by individual for at least 5 years: can exclude any capital gain on sale
- Individual limit of greater of: 10X adjusted basis; or $10M

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Changes to Qualified Small Business Stock, cont'd

- 1 BBB changes effective 7/4/25
- To qualify as a small business the aggregate gross assets of the corporation, before and after the issuance of the QSBS cannot exceed $75M
- Partial exclusions for shorter holding period:
  - Held for 3 yrs but less than 4 ……..50% exclusion of gain
  - Held for 4 yrs but less than 5 ……..75% exclusion of gain
  - Held for 5 yrs or more……100% exclusion of gain
- Individual limit on exclusion of greater of: 10X adjusted basis; or $15M ($10M if married filing separate)

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Changes to QSBS: Impact

- Allows greater opportunity for tax savings for individual founders/investors at more flexible levels
  - Greater individual limit for exclusion of gain
  - Shorter holding period to reap some benefits

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Litigation Over FA Deferred Compensation

- Morgan Stanley and Merrill Lynch have similar deferred compensation plans for advisors:
  - Defers a portion of compensation to plans subject to a vesting schedule longer than ERISA permits
  - Also vests on death, involuntary termination, and retirement
  - Advisors forfeit if leave voluntarily before vesting
- Advisors who left voluntarily forfeited and sued
  - Maintaining plan was subject to ERISA as employee pension benefit plan
    - Defers income beyond termination of employment
    - Therefore, vesting schedule violates ERISA and they shouldn't forfeit

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Litigation Over FA Deferred Compensation, cont'd

- In late 2023, NY district court held in Shafer that Morgan advisor claims are subject to arbitration
- Went on to say the plans are subject to ERISA
- In July 2025, 2nd Circuit denied Morgan's claim that ERISA question was for arbitrator

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Litigation Over FA Deferred Compensation, cont'd

- In September of 2025 EBSA issued Advisory Opinion 2025-03A concluding the Morgan plan was a bonus plan exempt from ERISA
- Not a retirement plan
  - Did not provide for retirement income or systemically defer income beyond termination of employment
- Was a bonus program exempt from Title I of ERISA
  - Express purpose to reward tenure and incentivize good behavior
  - Participants informed annually that it was not an ERISA retirement plan
  - Awards were unsecured and not guaranteed

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Litigation Over FA Deferred Compensation, cont'd

- In 2024 Merrill advisors who had left voluntarily sued in NC District Court
- Merrill filed Motion for Summary Judgment that was exempt from ERISA as a "bonus program"
- 3/11/25 Ct granted summary judgment in Milligan
  - Purpose of plan was not retirement but to reward EEs performance and tenure
  - Even if it were a pension plan, it was exempt as a bonus program
- In April Advisors appealed to 4th Circuit
  - Oral arguments held on 1/29/26 before 3 judge panel

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Litigation Over FA Deferred Compensation, cont'd

- In October 2025, Morgan advisors sued EBSA in New York, challenging Advisory Opinion 2025-03A in Sheresky
- Alleges DOL exceeded authority and acted arbitrarily and capriciously by:
  - Creating and applying impermissible "purpose test" for pension plan determination
  - Relied on invalid regulation for bonus plans
  - Failed to follow procedures regarding advisory opinions
  - Ignored contrary case law

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Summary-Scoreboard

- One NY District Court said subject to ERISA in Shafer
- One NC District Court (Milligan) and DOL say not subject to ERISA (Adv. Op. 2025-03A)
  - Milligan appeal waiting decision by 4th Circuit
  - DOL Adv. Op. being challenged in NY District Court (Sheresky)

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Conclusion

- Executive Compensation is a very important tool
- Changes in QSBS is good news for start-ups and individual investors
- Stay tuned for decisions on bonus programs

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Fiduciary Trends in Retirement Plans

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Cryptocurrency Investments in Defined Contribution Plans

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Cryptocurrency Investments in 401(k) Plans

- On March 10, 2022, the DOL issued Compliance Assistance Release 2022-01 ("CAR 2022-01")
- CAR 2022-01 cautioned fiduciaries to exercise "extreme caution" before they consider adding cryptocurrencies in the plan's investment lineup

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Cryptocurrency Investments in 401(k) Plans, cont'd

- Cryptocurrency risks/concerns:
  - Speculative and volatile
    - Example: In 2026, Bitcoin is down almost 25% YTD
  - Evolving regulatory environment
    - Example: Participants could inadvertently engage in unlawful transactions
  - Difficulty to make informed investment decisions
    - Participants lack the knowledge and technical expertise
  - Custodial and recordkeeping concerns
    - Example: Cryptocurrencies are not held like traditional plan assets in trust or custodial accounts
  - Valuation challenges
    - Experts have described the question of how to appropriately value cryptocurrencies as complex and challenging

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Cryptocurrency Investments in 401(k) Plans, cont'd

- On May 28, 2025, the DOL released Compliance Assistance Release No. 2025-01, revoking CAR 2022-01 stating that the standard of "extreme care" is not found in ERISA and differs from ordinary ERISA fiduciary principles
  - Restored previous "neutral" approach to specific investment types and strategies leaving the decision to include cryptocurrency to fiduciaries subject to fiduciary duties of prudence and loyalty
- Revocation of CAR 2022-01 doesn't endorse cryptocurrency, but it eliminates the previous heightened scrutiny and aligns its treatment with other investment choices
- The appropriateness of cryptocurrency as an investment should focus on the specific needs of the plan, the unique characteristics of the population, and the reasonableness of the fiduciaries' judgment

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Alternative Assets for Defined Contribution Plans

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Alternative Assets for Defined Contribution Plans

- On August 7, 2025, the President signed an Executive Order titled, "Democratizing Access to Alternative Assets for 401(k) Investors" (the "Order")
- The Order seeks to close the gap in access to growth and diversification opportunities between DC plans and DB plans by easing regulatory and litigation burdens
- The Order directs the DOL to review and update guidance on the use of alternative asset investments in DC plans and to clarify fiduciary expectations
  - On August 12, 2025, the DOL rescinded its Supplemental Statement on Private Equity in Defined Contribution Plans issued on December 21, 2021
- The Order gives the DOL 180 days to issue guidance explaining fiduciary duties when deciding whether to include alternative investments in DC plans, potentially including streamlined fiduciary safe harbor frameworks

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Alternative Assets Defined

- "Alternative Assets" are broadly defined to include:
  - private market investments (e.g., private equity, private credit, and other non-public instruments)
  - real estate
  - digital assets
  - commodities
  - infrastructure financing, and
  - lifetime income strategies

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Past Access to Alternative Investments

- Private equity investments were not prohibited under ERISA prior to the Order
- Pre-2020, there was limited use due to the risks associated with private equity investments
- On June 3, 2020, the DOL issued an Information Letter permitting private equity as a component of diversified funds (e.g., target-date or balanced funds), subject to prudent fiduciary process
  - Did not approve standalone private equity funds
- On December 21, 2021, the DOL clarified that private equity in 401(k) plans carry unique risks and complexities, and that fiduciaries should not assume the 2020 Information Letter generally endorsed private equity for typical participant-directed plans

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Potential Risks and Challenges

- **Illiquidity:** Many alternative assets lock up capital for years, reducing participant flexibility
- **Valuation Challenges:** Alternative assets often lack clear benchmarks and provide limited transparency. They are typically not valued on a daily basis, and valuations may rely on manager-provided estimates, which can introduce potential conflicts of interest
- **Higher Costs:** Fees are often higher, which can meaningfully reduce participant returns
- **Potential for Significant Volatility:** Certain assets, such as commodities, digital assets, and some hedge strategies, can experience sharp price swings and higher short-term risk

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Fiduciary Considerations

- The Order itself does not alter ERISA's principle fiduciary standards, including the prudence and loyalty standards. Plan fiduciaries should treat alternative investments with the same level of care and caution
- The Order instructs the DOL to release guidance clarifying the duties an ERISA fiduciary owes to plan participants when deciding whether to make available alternative asset investments available in DC plans
  - Provide clarification on how plan fiduciaries can weigh the costs and benefits of including alternative assets
  - Provide guidance on how plan fiduciaries should make decisions when including alternative assets in target-date or other asset allocation funds.
  - May also introduce a fiduciary safe harbor
- Courts will not be required to defer to DOL's interpretation of fiduciary responsibility

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Proxy Voting: A Complex Evolution

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Proxy Voting: A Complex Evolution

- ERISA Plans hold significant proxy voting power
- As of the end of 2025, ERISA plans hold approximately $14.6 billion in assets, the vast majority of which are invested in underlying stock holdings. As a result, ERISA plans hold significant proxy voting power

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Proxy Voting in ERISA Plans

- Who votes proxies?
  - Mutual Funds: Proxies are generally voted by the trustee. In some participant directed plans, the trustee will "pass through" voting rights to participants and follow a written policy for unvoted shares
  - Collective Trusts/Separate Accounts: Proxies are generally voted by the fund investment managers

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Proxy Voting in ERISA Plans, cont'd

- ERISA guidance around proxy voting
- In December 2022, DOL issued a final rule confirming that ERISA's fiduciary duties of loyalty and prudence apply to proxy voting and shareholder rights. The final rule generally provides:
  - Fiduciaries must act prudently and loyally, considering *risk-return factors* when voting proxies
    - Note that the rule does not apply to proxies or rights voted by participants
  - Whether a proxy should be voted at all is a matter of fiduciary judgment

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Proxy Voting in ERISA Plans, cont'd

- 2025 Novel Litigation
- *Spence v. American Airlines, Inc.* 775 F. Supp. 3d 963 (N.D. Tex. 2025)
  - Proxy voting is not peripheral—it is a fiduciary act
  - ERISA's duties of prudence and loyalty apply directly to proxy voting
  - Plan fiduciaries must monitor how delegated managers vote shares
- Opinion is significant because it is the first major court decision concluding ERISA fiduciaries can be liable for proxy voting decisions of investment managers

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Proxy Voting in ERISA Plans, cont'd

- 2025 Regulatory and Political Shift
- On December 11, 2025, President Trump issued Executive Order 14366, *"Protecting American Investors from Foreign-Owned and Politically-Motivated Proxy Advisors"*
  - Directive focuses on the role of *proxy advisory firms* and instructs agencies including DOL, SEC, and FTC to review/revise rules, guidance, or enforcement related to proxy voting and proxy advisors
  - Directs a policy review over concern that proxy advisors prioritize *DEI and ESG agendas* over returns

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Proxy Voting in ERISA Plans, cont'd

2026 Congressional Activity

The House recently passed the *Protecting Prudent Investment of Retirement Savings Act* (H.R. 2988). It would amend ERISA to:

- Reinforce financial-only standards for proxy voting (limiting ESG-type considerations unless clearly economically tied)
- Codify fiduciary duties specific to proxy voting, including *documenting how proxy votes were decided* and monitoring managers and advisors
- Currently in Senate fate uncertain

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Proxy Voting in ERISA Plans, cont'd

Conclusion

- The legal landscape is *in flux*—fiduciaries must follow current rules but anticipate new DOL and/or statutory standards that emphasize financial returns and tighter oversight of proxy practice
- Consider reviewing investment management agreements for adherence to ERISA in proxy voting
- Anticipate regulatory developments in the coming year

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2026 DOL-EBSA Enforcement Priorities

- On January 16, 2026, the DOL released updates to its national enforcement projects for employee benefit plans
- The updates highlight where EBSA will focus its enforcement resources to increase compliance and address abuse

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2026 DOL-EBSA Enforcement Priorities, cont'd

- Cybersecurity
  - Cybersecurity was recategorized from "important" to "priority"
  - Cybersecurity has been a focus of DOL investigations since 2021
  - Recategorizing as a priority demonstrates continued concern and commitment by EBSA

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2026 DOL-EBSA Enforcement Priorities, cont'd

Investment Selection Prudence Three-Prong Approach:

- Service provider reviews of 3(21) advisors and 3(38) managers
- Investment selection process in 404(c) plans
- Investment selection process in underfunded defined benefit plans

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Fiduciary Recommendations

- Understand your fiduciary duties
- Update and follow documents (e.g., IPS)
- Review cybersecurity plans and controls, including with service providers
- Implement a structured monitoring framework for advisors and investment menus, with clear documentation of review criteria and follow-up actions
- Assess proxy voting oversight
- Document, document, document

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