ISSUES
EMPLOYEE BENEFITS

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What's Inside

Companies Should Consider Modifying "Change in Control" Definitions in Executive Compensation Arrangements to Avoid Unintended Payment Trigger

Last year, a federal court considered whether a "change in control" had occurred under the terms of a company's Executive Severance Agreement (the "ESA"). The court's decision provides guidance on how a court might interpret a change in control definition under executive compensation arrangements and highlights the need for some companies to consider modifying their definitions for clarity.

Facts of the Case

Under the facts of the case, two investors in the company acting separately began to buy shares of the company, eventually acquiring over 25% of the company between the two of them. Through

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ERISA's Fiduciary Duties Can Exceed Statutory Disclosure Requirements

Employee benefit plan fiduciaries understand that ERISA requires them to act "with the care, skill, prudence, and diligence" of a prudent "expert," which includes making certain disclosures to the participants in their plan. However, this standard may require more than simply meeting the statutory minimums outlined in ERISA or the Internal Revenue Code, after consideration of all relevant facts and circumstances:

Several distinct categories give rise to disclosure-related fiduciary duties: (1) statutory disclosures; (2) direct inquiries by participants or beneficiaries; (3) circumstances when silence would be harmful to the participant; and (4) impending changes to benefit plans that are under serious consideration. This article summarizes these categories and how fiduciaries can best protect themselves from ERISA claims of breaching fiduciary duties.

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Mental Health Parity and Addiction Equity Act

The Consolidated Appropriations Act, 2021 (the "CAA") was signed into law on December 27, 2020. The CAA imposes a substantial new requirement that a group health plan perform and document its compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA"). Specifically, group health plans must generate a comparative analysis of the plan's mental health, substance use disorder ("MH/SUD"), and medical/surgery ("M/S") nonquantitative treatment limitations to demonstrate the plan does not impose less favorable benefit limitations on MH/SUD treatments. As of February 10, 2021, group health plans are required to produce the comparative analysis to state regulators, federal regulators, and participants upon request.

The MHPAEA provides that financial requirements (i.e., quantitative treatment limits), such as coinsurance and copays, cannot be more restrictive or applied in such a way that makes it more difficult for participants to receive treatment for MH/SUD than M/S benefits. The same requirements exist for nonquantitative treatment limitations ("NQTLs") such as prior authorization, step therapies, or distance standards. Ensuring that NQTLs are not being improperly applied with respect to MH/SUD is an inherently more difficult endeavor than measuring a quantitative treatment; a copayment obligation is readily, and easily, measured and compared. If the MH/SUD copay is more expensive than the M/S copay, it is simple to determine that an impermissible benefit limitation in violation of MHPAEA has occurred. The CAA aims to allow for easier enforcement of the MHPAEA with respect to NQTLs by requiring plans to show their work, both in design and application, with respect to their use of NQTLs in limiting treatments for MH/SUD.

There are six classifications of NQTLs that must be separately considered when drafting the comparative analysis: inpatient (in and out-of-network), outpatient (in and out-of-network), emergency care, and prescription drugs. Each of these six different classifications must separately meet the NQTL parity test. The comparative analysis, considering each of the six classifications, must contain:

- Plan Terms: The specific plan terms regarding NQTLs and a description of all MH/SUD and M/S benefits to which the NQTLs apply in each classification.
- Factors: The factors used to determine that NQTLs should apply to MH/SUD and M/S benefits.
- Evidentiary Standards: The standards used for the factors and the evidence relied upon to design and apply the NQTLs to MH/SUD and M/S benefits.
- Comparative Analyses: An analysis demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, those used to apply the NQTLs to M/S benefits in the classification.
- Findings: Findings and conclusions the plan reached.

A failure to provide the analysis upon request (or providing an analysis that reveals noncompliance with the MHPAEA) may result in $100 per day penalties per affected individual, possible general ERISA penalties, or civil litigation (both public and private). Should the Department of Labor ("DOL") determine that the plan is not MHPAEA-compliant, the plan has 45 days to rectify the issue and produce a new comparative analysis. As further evidence that MHPAEA enforcement is going to be a priority, the CAA requires the DOL to require a noncompliant plan to notify all individuals enrolled in the plan that its coverage is not MHPAEA-compliant. The CAA further requires the DOL to generate an annual public report of noncompliant plans. This public report must be submitted to Congress and include the name of the plan and/or issuer.

The CAA only requires the DOL to request 20 comparative analyses per year. This small number of required requests does not adequately convey the urgency upon group health plans to draft the comparative analysis: as noted above, participants and state regulators are also entitled to the comparative analysis upon request. A participant complaint to the DOL regarding a plan's failure to provide the analysis is likely to get the DOL's attention.

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Indeed, while it is unclear how many comparative analyses requests the DOL has made in practice, there is concrete evidence that they are focused on MHPAEA compliance generally. A recent $15 million settlement with UnitedHealth Insurance and affiliates (*Walsh v. United Behavioral Health*, E.D.N.Y. No. 1:21cv04519) included $2 million in ERISA penalties for MHPAEA violations. Simply put, if a group health plan has not been proactive regarding the comparative analysis when it receives a request for its production, it may already be too late. The plan would of course have 45 days to produce the analysis but producing such a draft in a relatively short amount of time would be difficult (and perhaps prohibitive) for many selfinsured plans.

For a fully insured plan, the insurance carrier will generally be responsible for generating the comparative analysis, as plan design and claims processing largely remain under the carrier's purview. A self-funded plan will require the plan sponsor to draft the comparative analysis. It appears that many third-party administrators are unwilling to produce the comparative analysis, which places a heavy burden on self-funded plan sponsors. In any event, the self-funded group health plan remains responsible for assuring the plan's compliance with the MHPAEA. It would be prudent for selffunded group health plan sponsors to work with counsel in drafting their comparative analysis.

New HHS Interpretation of Section 1557 Expands Plan Sponsor Obligations

Background: Bostock and Its Impact

On June 10, 2020, the United States Supreme Court issued a decision in *Bostock v. Clayton County, GA* (2020) and held that Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination based on sex, encompasses discrimination based on sexual orientation and gender identity.

The *Bostock* opinion firmly concluded that it "is impossible to discriminate [against] a person for being homosexual or transgender without discriminating against that individual based on sex." Consequently, the plain language of Title VII's phrase "because of sex" must include discrimination because of sexual orientation. Soon after the Supreme Court's ruling in *Bostock*, the Fourth and Eleventh Circuits ruled that similar reasoning could be applied to Title IX, which prohibits discrimination on the basis of sex in any school or other federally funded educational activity. Further, the Federal Agency Civil Rights Directors and General Counsels issued a memorandum in March 2021 stating that the "best reading" of Title IX's prohibition on discrimination "on the basis of sex" includes discrimination on the basis of gender identity and sexual orientation.

Section 1557 and Title IX

To further address the aims of the Affordable Care Act's goal of expanding health care access and coverage, Section 1557 of the Affordable Care Act ("ACA") prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. However, Section 1557 has no enforcement mechanisms in and of itself. Instead, Section 1557 finds its enforcement mechanisms provided for and available under Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Title IX of the Education Amendments of 1972. Consequently, determining that gender identity and sexual orientation are encompassed by Title IX necessarily means that discrimination based on gender identity and sexual orientation are also prohibited by the ACA.

Almost a year after *Bostock*, on May 10, 2021, the Department of Health and Human Services ("HHS") announced that, in light of *Bostock* and ensuing opinions, it would be interpreting and enforcing Section 1557 of the ACA's prohibition on discrimination on the basis of sex to similarly encompass discrimination on the basis of sexual orientation and gender identity.

Notably, the May 2021 announcement effectively repealed an HHS Office for Civil Rights Final Rule issued June 12, 2020 that narrowed Section 1557's reading of "on the basis of sex" to exclude gender identity, effectively removing any previous protections for transgender individuals. These protections were initially challenged in 2016 before the notice of proposed rulemaking in 2019. As a result, HHS Office for

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their position, they were eventually able to acquire three seats on the board of directors of the company—one to be controlled by each individually, and another to be controlled by mutual agreement between the two. In a single month, four board members resigned; three of whom were replaced by the two investors and the fourth of whom was replaced by the board.

Pursuant to the ESA, executive participants were entitled to enhanced severance benefits in the event of a termination following change in control. The ESA defined a change in control (in simplified language) as (i) any person or "group" obtaining 25% or more of the combined voting power of the company's securities, or (ii) replacement of one-fourth of the company's directors without approval of at least two-thirds of the directors then in office, with the caveat that there is no "approval" where there is a threatened election contest.

The facts of the case:

- Two investors in the company acting separately began to buy shares of the company, eventually acquiring over 25% of the company
- Through their position, they were eventually able to acquire three seats on the board of directors of the company
- In a single month, four board members resigned; three of whom were replaced by the two investors

Claims and Rulings

The participants made two arguments. First, they argued there was a change in control because the two investors were a "group" who acquired more than 25% voting power. The court ruled in favor of the company on this argument, declaring that the investors were not a "group." In fact, the investors were hostile to each other and working independently.

Second, the participants argued there was a change in control because a sufficient number of board seats changed, and the change was due to a threatened election contest (nullifying any "approval" of current directors). The court decided in favor of the participants on this argument, ruling that, although there was no explicit threat of a proxy contest, the threat may have been implicit, and the second argument should go to trial.

Recommendations

Based on this ruling, companies with executive compensation arrangements should review their change in control triggers to determine if the definition of change in control therein has the intended result. A company may wish for the actions of separate individuals not acting as a group to trigger a change in control upon certain changes in ownership or voting power; in those cases, references to people acting as a "group" or citations to specific Code sections may need to be removed or clarified. Alternatively, a company may wish for changes in ownership or voting power to trigger a change in control *only* due to a coordinated effort; in those cases, references to people acting as a "group" or citations to specific Code sections may need to be added or clarified. In addition, companies will want to determine what types of board turnover should trigger a change in control and adjust their definitions accordingly. Finally, it is best practice to include carve-outs, if any, indicating what types of changes should not constitute a change in control (for example, an IPO or a large change in ownership or voting power that still leaves certain shareholders with a large stake) or, if applicable, what types of changes should constitute a change in control.

If you need assistance in modifying your control definitions based on this article, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

A Summary of the Consolidated Appropriations Act's Employee Benefits Provisions

The Consolidated Appropriations Act, 2021 (the "CAA") was signed into law on December 27, 2020. The CAA was a large and complicated bill, consisting of approximately $2.3 trillion dollars of spending laid out in its 5,593 pages. The CAA is best known for providing many Americans with a $600 stimulus check due to the ongoing pandemic and averting a government shutdown. However, the CAA also included major changes to group health plans ("health plans"), health and dependent care flexible spending arrangements (collectively, "FSAs"), educational assistance programs, and retirement plans.

This article summarizes the major provisions of the CAA that affect employee benefit plans and provides action steps for employers to implement these changes. For more detailed information about the CAA and its provisions, please contact the Kutak Rock Employee Benefits and Executive Compensation practice group.

Health Plan Provisions

Unless otherwise specified, the effective date for the health plan changes is January 1, 2022:

- *Surprise Billing Limitations and Related Requirements*. The

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Congressional Leadership Seeks Additional Information on Target Date Funds

Since their introduction in the 1990s, target date funds have grown to comprise the majority of assets in most qualified defined contribution plans. However, recent questions from Congressional leadership suggest that there are potential concerns with how these funds are operated, particularly in light of guidance from the Trump administration and the impact of COVID 19 on the markets. These questions, in turn, give plan fiduciaries additional factors to assess in reviewing target date funds.

Congressional Request for Information

In May, Senator Patty Murray (Chair of the Senate Committee on Health, Education, Labor & Pensions) and Representative Robert Scott (Chairman of the House Committee on Education & Labor) asked the Government Accountability Office ("GAO") to conduct a review of target date funds. Their letter reflected several concerns. Notably:

- The expense and risk allocation of target date funds vary significantly among target date funds on the market, even when participants are close to retirement, and are sometimes significantly higher than available benchmarks (such as the target date funds offered under the Thrift Savings Plan).
- Participants may not be encouraged to review target date funds because of the ways in which they are marketed.
- The Trump administration introduced the possibility for higher risk alternative investments in target date funds and there is very little data on the utilization of such alternative investments.
- The questions suggested in the letter to the GAO suggest a few different concerns regarding target date funds on the part of Congressional leadership, specifically with respect to the impact of the pandemic on target date funds, utilization of the funds and alternative investments in them, how investors reassess the funds and their glide paths, fund marketing, and off the shelf versus custom target date funds.

Potential Questions for Plan Fiduciaries

Although the GAO has not formally addressed Senator Murray and Representative Scott's letter yet, the letter provides some insight on potential factors plaintiffs' attorneys might look at in the future and additional due diligence that plan fiduciaries can perform. Specifically, plan fiduciaries might consider asking:

- How their target date funds performed during the pandemic, especially with respect to funds for participants close to retirement;
- How the expenses of the target date funds compared to other hypothetical portfolios that could be constructed using the plan's menu; and
- Whether it would be appropriate to develop communications to participants educating them on the plan's target date fund and reassessing their investment time horizon.

It is unclear at this point whether the GAO will engage in a more formal inquiry regarding target date funds. However, Senator Murray and Representative Scott's letter provides some useful insight regarding potential avenues of inquiry regarding target date funds in addition to those discussed in the Department of Labor's prior guidance.

Recent Cases Highlight Potential Issues With Cross Plan Offsetting

Over the past few years, federal courts have responded in different ways to cross plan offsetting and the question of whether it constitutes a breach of fiduciary duty under ERISA. In general, cross plan offsetting occurs when (a) one health plan ("Plan A") overpays a provider for services, (b) the provider declines to reimburse the overpayment and (c) an insurer or third-party administrator recoups the overpayment by paying that provider less when a different participant from a different plan ("Plan B") receives services from the same provider. The provider is paid less for the subsequent service to offset the previously overpaid amount, and each plan's account is debited/credited accordingly. This Client article examines recent court cases involving cross plan offsetting to highlight the potential issues employers should consider.

Eighth Circuit Considers Cross Plan Offsetting

In 2019, the United States Court of Appeals for the Eighth Circuit addressed cross plan offsetting in *Peterson v. UnitedHealth Group*. Out of network providers challenged UnitedHealthcare's cross plan offsetting practices, claiming the plan documents did not authorize UHC to engage in them. The Eighth Circuit agreed with those providers. While it did not decide whether cross plan offsetting violates ERISA, the court noted that the practice was "in some tension with the requirements of ERISA," particularly a fiduciary's duty to act for the exclusive purpose of providing benefits to participants and their beneficiaries.

Importantly, the U.S. Department of Labor (the "DOL") submitted a brief to the Eighth Circuit arguing that cross plan offsetting is a breach of the duty of loyalty and a prohibited transaction under ERISA. The DOL explained that the practice exposed participants in Plan B to a risk of balance billing by out of network providers. In addition, the DOL argued cross plan offsetting is a prohibited transaction because it involves transferring assets from Plan B to benefit Plan A's loss from a past overpayment. The DOL implied that some of its concerns may be limited to cross plan offsetting involving out of network providers; in network providers typically have contracts with a plan that prevent balance billing.

Another Court Determines Participants Cannot Sue for Cross Plan Offsetting

In May 2021, a federal district court in Minnesota dismissed plaintiffs' complaint alleging that a third-party administrator misused participant funds when it engaged in cross plan offsetting. The plan participants argued cross plan offsetting violated the third party administrator's ERISA duty of loyalty, prohibition on self dealing, and

Action Items for Plan Sponsors

In light of courts' varying responses to cross plan offsetting, plan sponsors should determine whether their insurers or third-party administrators are engaging in the practice. Additionally, plan sponsors should:

- Review plan documents and summary plan descriptions to verify the plan authorizes cross plan offsetting;
- Review administrative service agreements with third-party administrators to determine whether it is possible to opt out of cross plan offsetting or limit the practice to in network providers;
- Confirm that plan notices explain the impact cross plan offsetting has on benefits (e.g., the practice does not result in a denial of benefits); and
- Monitor the scope and disposition of future cross plan offsetting litigation.

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transacting with a party in interest. The court dismissed the lawsuit, reasoning that the participants did not directly experience a loss or denial of benefits, but rather the plan experienced a loss when its funds were used to offset other plans' overpayments. Because the participants were not injured by cross plan offsetting, the court determined they could not sue and did not opine on the breach of fiduciary duty issue.

Another Court Determines Cross Plan Offsetting Is a Breach of Fiduciary Duty

Most recently, in June 2021, a New Jersey federal district court held, in an unpublished opinion, that a third party administrator's cross plan offsetting practice constitutes a breach of fiduciary duty of loyalty and a prohibited transaction. An out of network provider claimed that an insurer/third party administrator's cross plan offsetting violated ERISA's duty of loyalty and prohibited transaction rules. The provider also asserted that the plan documents for the plans from which the payments were withheld did not authorize cross plan offsetting (only same plan offsetting). The court agreed, applying rationale that largely echoed the DOL's brief in Peterson.

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- Confirm that plan notices explain the impact cross plan offsetting has on benefits (e.g., the practice does not result in a denial of benefits); and
- Monitor the scope and disposition of future cross plan offsetting litigation.

If you have any questions about cross plan offsetting and how it affects your group health plans or need assistance reviewing and negotiating the plan documents or service agreements, please contact a member of the Kutak Rock Employee Benefits group.

Eligible Medical Expenses Related to the Coronavirus Pandemic

During the ongoing coronavirus pandemic, many people have purchased personal protective equipment (e.g., masks, hand sanitizer, disinfectant, or sanitizing wipes) to prevent infection or spread of the virus or have bought home test kits to diagnose a potential existing infection. The IRS has issued guidance stating that the purchase of items necessary to diagnose or prevent coronavirus infection are treated as amounts paid for medical care under Code Section 213(d).

Consequently, protective equipment and testing kits can be purchased or reimbursed through health flexible spending arrangements ("health FSAs"), health savings accounts ("HSAs"), health reimbursement arrangements ("HRAs"), or Archer medical savings accounts ("Archer MSAs"). Alternatively, the cost of such items may be tax-deductible, so long as they are not compensated by insurance and the taxpayer's total medical expenses exceed 7.5% of adjusted gross income. If you have questions about the reimbursement of eligible medical expenses, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

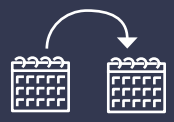
IR 2021-66, IR-2021-181

Amendment Deadline for CAA Cafeteria Plan Changes Fast Approaching

The Consolidated Appropriations Act ("CAA") made several temporary changes to health flexible spending accounts ("health FSAs") and dependent care assistance programs ("DCAPs") in 2020 and 2021.

Any or all of these changes may be made at a plan sponsor's election:

- All unused 2020 health FSA and/or DCAP funds may be carried over to 2021; unused 2021 health FSA and/or DCAP funds may be carried over to 2022. For context, carryovers are typically capped at $550 and are not permitted in DCAPs.
- A grace period associated with a plan year ending in 2020 or 2021 may be extended up to 12 months after the end of the plan year. Grace periods are typically no longer than two and one-half months. (Remember, a plan may allow carryovers or have a grace period but cannot do both.)
- Participants may make prospective mid-year election changes to their health FSA or DCAP in 2021 without experiencing a change in status.
- Participants who terminate employment in 2020 or 2021 may continue to be reimbursed for eligible expenses through the end of that plan year if they had unused health FSA or DCAP funds at termination.
- DCAPs only: The eligible expenses of a dependent who aged out during the 2020 plan year may be reimbursed for one additional year, until the dependent turns 14 years old. Typically, dependents age out when they turn 13 years old.



Carried over

Grace period

Election changes

Reimbursement

Dependent age out

Internal Revenue Service guidance (Notice 2021-15) supplemented the CAA changes by noting that the carryover and grace period relief are available to plans regardless of whether they currently have a carryover or grace period. Further, DCAPs, while they typically do not allow carryover of unused funds, may temporarily adopt a carryover, subject to the same rules as a health FSA. The Notice also provided that unused funds carried over from the immediately preceding plan year or available during an extended grace period do not count toward a participant's annual contribution limit in the following year.

With respect to mid-year election changes, the Notice clarifies that employees may prospectively revoke an election, make an election or increase/decrease an existing election for their health FSA and/or DCAP for plan years ending in 2021. An employer may limit the number of mid-year changes an employee may make during this period. Additionally, an employer may limit the extent to which an employee may revoke an election to amounts already contributed.

If you would like to adopt any of these changes, action must be taken no later than the last day of the calendar year after the end of the plan year to which the changes relate. Generally, this means that changes to the 2020 plan year must be adopted no later than December 31, 2021 and changes to the 2021 plan year must be adopted no later than December 31, 2022. Each of these changes requires a plan amendment (and corresponding updates to the plan's summary plan description).

SECURE Act 2.0

On the heels of Congress's 2019 "Setting Every Community Up for Retirement Enhancement Act" (the "SECURE Act"), new retirement legislation informally dubbed "SECURE Act 2.0" is currently awaiting Congressional approval. SECURE Act 2.0 consists of two significant legislative proposals that focus on enhancing retirement plan access and administration—the House's Securing a Strong Retirement Act of 2021 and the Senate's Retirement Security and Savings Act of 2021. The Securing a Strong Retirement Act passed the House Ways and Means Committee by a unanimous vote on May 5, 2021. The Retirement Security and Savings Act was reintroduced in the Senate a couple of weeks later. Based on strong bipartisan support, it is widely believed that SECURE Act 2.0 will become law in the coming months.

The proposed legislation includes the following key retirement plan changes:

- Increases the small employer pension plan start up credit to cover 100% of the cost to small employers to implement a 401(k) plan for the first three years.
- Creates a new credit to encourage small employers to make employer contributions ($1,000 per employee).
- Expands automatic enrollment by requiring new defined contribution plans to implement automatic enrollment.
- Increases the required minimum distribution age from 72 to 73 starting in 2022, 74 starting in 2029, and 75 starting in 2032.
- Increases the annual catch up limit from $6,500 to $10,000 for ages 62 to 64.
- Subjects all catch up contributions to Roth tax treatment.
- Permits employees to elect Roth tax treatment for matching contributions.
- Permits matching contributions based on employees' student loan repayments.
- Allows 403(b) plans to utilize collective investment trusts.

Statutory Disclosure Requirements

Plan fiduciaries owe myriad disclosure obligations to participants and beneficiaries, such as distributing summary plan descriptions ("SPDs"), summaries of material modifications ("SMMs"), periodic benefits statements, plan fees and investment notices, and requested plan documents.

Statutory disclosures are among the most straightforward obligations since explicit delivery and timing procedures are outlined in Labor and Treasury regulations. Fiduciaries encounter issues with statutory requirements when disclosures are not timely distributed, are not written in a manner to be understood by average participants, and are not delivered due to administrative issues. System failures and technical deficiencies can elicit statutory penalties under ERISA, additional taxes, and steep litigation costs.

Participant Requests for Information

The next category of disclosure-related fiduciary duties stems from participants inquiring about their benefits under an ERISA plan. When a participant specifically requests information, fiduciaries are held to an elevated standard: the fiduciary must provide complete and accurate information concerning the information requested, all in a timely fashion.

In *Eddy v. Colonial Life Ins*., the employer, Unitag, terminated the company's group health plan. As a result Mr. Eddy asked Colonial Life, the insurance company, about the status of his insurance coverage. The Colonial Life agent essentially told Mr. Eddy that he had no options, but it turned out that there was an option to convert the employer's group policy into an individual policy. In holding that Colonial Life breached its fiduciary duty to Mr. Eddy, the D.C. Circuit explained that the insurance company had to do more than not misinform. Rather, it had an affirmative obligation to inform Mr. Eddy about his insurance status and his conversion options.

Eddy and similar cases illustrate that when a participant explicitly asks about the status of his or her coverage, fiduciaries must be timely, accurate and thorough.

Substantial Likelihood That Silence Would Be Harmful

The third situation leading to enhanced fiduciary duties is when there is a substantial likelihood that silence would be harmful. In jurisdictions that recognize this duty, it emerges regardless of whether the participant asks about his or her benefits.

Harmful silence situations include ambiguous plan documents or administrative practices. In *Estate of Foster v. American Marine SVS Group Benefit Plan*, the Ninth Circuit held that an employer failed to provide a life insurance participant with adequate notice of his right to convert a group policy into an individual policy. The SPD did not clearly indicate whether the participant's 31-day conversion period began on February 29 (month he was laid off), April 30 (month he stopped receiving pay), or a later date based on an exception for participants who were totally disabled. The employer had a duty to provide more complete information concerning the participant's conversion rights since the SPD was not entirely clear about when the life insurance policy would terminate.

The Ninth Circuit warned that sending an SPD can be sufficient but is not always enough. The critical inquiry is whether in a particular circumstance the employer has done enough "to provide complete and accurate information."

Serious Consideration Doctrine

Finally, an enhanced fiduciary duty commences when an employer gives serious consideration to plan changes. Amending or terminating a plan is a settlor function, not a fiduciary function, but conveying information to participants about future plan benefits does entail a fiduciary act. While employers have a business interest in protecting future business plans (and plan design changes) from premature disclosure, employees also have a right to disclosures relating to their benefit plans.

Under the Third Circuit's widely adopted test, a plan change is under serious consideration when (1) a specific proposal (2) is being discussed for the purposes of implementation (3) by senior management with authority to implement the change. When this occurs, fiduciaries may have the affirmative duty to inform impacted participants about the possible plan change.

Consequences of Failing To Provide the Foregoing Disclosures

If a plaintiff succeeds in a breach of fiduciary duty lawsuit arising from a disclosure failure, the remedy will likely be "appropriate equitable relief." Appropriate equitable relief can include money damages imposed on the breaching fiduciary (including personal liability). In light of various circumstances that require heightened duties, fiduciaries must be mindful of falling into one of these categories when communicating with participants.

If you have further questions about the disclosure requirements imposed on plan fiduciaries, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

IRS Issues Final Regulations Regarding Excise Tax on Excess Compensation Under Code Section 4960

Section 4960 of the Internal Revenue Code imposes a 21% excise tax on compensation exceeding $1 million paid by an applicable tax-exempt organization ("ATEO") and related organizations to covered employees (generally the five highest paid employees of the organization for the taxable year). In 2019, the IRS issued interim guidance, Notice 2019 09, followed by proposed regulations in 2020.

On January 19, 2021, the IRS issued final regulations that largely track Notice 2019 09 and the proposed regulations, with several clarifications and modifications. The final regulations apply to tax years beginning after December 31, 2021.

ATEOs and Related Organizations

Consistent with the proposed regulations, ATEOs include every organization that: (1) is exempt from tax under IRC Section 501(a); (2) is a farmers' cooperative organization under IRC Section 521(b)(1); (3) has income excluded from taxation under IRC Section 115(1); or (4) is a political organization described in IRC Section 527(e)(1). Like the proposed regulations, the final regulations require that remuneration for each covered employee include not only remuneration from the ATEO but also remuneration from all related organizations. Organizations can be related based on various factors, including voting rights, partnership interests, or control over the organization's board or governing body. An organization is considered a related organization based on a controlled group analysis using a 50% threshold.

The final regulations contain two notable exceptions to ATEO status. First, Section 4960 does not apply to governmental entities that claim exemption from federal income tax based on sovereign immunity—including many public universities—but only if the entity is not also tax-exempt under Section 501(a). Foreign organizations described in IRC Section 4948(b) are also excluded from ATEO status if they are exempt from tax under IRC Section 501(a) or are taxable foundations described in IRC Section 4948(b).

Covered Employees

The final regulations confirm that a covered employee of an ATEO remains a covered employee for all subsequent tax years, even after the employment relationship has terminated. The proposed regulations created two exceptions for ATEOs affiliated with for profit organizations under which certain individuals are not treated as covered employees—the "limited hours" exception and the "non exempt funds" exception.

The final regulations adopted the limited hours exception in substantially the same form as set forth in the proposed regulations. Under this exception, an individual is not a covered employee if the hours the employee works for the ATEO make up 10% or less of the total time he or she works for the ATEO and all related organizations during the year. An individual is deemed to automatically satisfy the limited hours exception if that individual works no more than 100 hours for the ATEO and all related organizations during the year.

The final regulations adopted a modified version of the nonexempt funds exception. Under this exception, an individual is not a covered employee if the individual does not perform services for the ATEO

Section 4960 of the Internal Revenue Code imposes a 21% excise tax on compensation exceeding $1 million paid by an applicable tax-exempt organization ("ATEO").

ATEOs include every organization that:

1. is exempt from tax under IRC Section 501(a)
2. is a farmers' cooperative organization under IRC Section 521(b)(1)
3. has income excluded from taxation under IRC Section 115(1)
4. is a political organization described in IRC Section 527(e)(1)

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U.S. Department of Labor Issues Missing Participant Guidance

The Employee Benefits Security Administration division of the U.S.

Department of Labor ("DOL") is responsible for administering and enforcing the fiduciary, reporting and disclosure provisions of Title I of ERISA and has focused its enforcement efforts in recent years on the maintenance of complete and accurate census information by plan fiduciaries. To that end, the DOL issued guidance on January 12, 2021 describing best practices that prudent retirement plan fiduciaries should consider implementing to ensure that plan participants receive promised benefits when they reach retirement age. This guidance is consistent with positions taken by the DOL in enforcement investigations.

The guidance first identified several "red flags" that indicate that a plan has a problem with missing or nonresponsive participants:

- More than a small number of missing or nonresponsive participants.
- More than a small number of vested participants who have reached normal retirement age but have not started receiving their pension benefits.
- Missing, inaccurate, or incomplete contact information or census data, or both.
- Absence of sound policies and procedures for handling undeliverable mail or email.
- Absence of sound policies and procedures for handling uncashed or stale checks.

By contrast, plans that have low numbers of missing and nonresponsive participants demonstrate an "ongoing culture of fiduciary compliance" and have implemented some or all of the following best practices:

Maintain accurate census information for the plan's population by:

- Periodically contacting current and retired participants to confirm or update contact information for themselves and beneficiaries.
- Including contact information change requests in plan communications along with reminders to advise the plan of any contact information changes.
- Flagging undelivered communications and uncashed checks for follow-ups.
- Maintaining and monitoring an online platform for the plan that participants can use to update contact information for themselves/beneficiaries.
- Providing prompts for participants/beneficiaries to update contact information when they log in to online platforms.
- Conducting regular audits of census information and correcting any errors found.
- In the case of business mergers/acquisitions or a change of record keepers, making missing participant searches and employer records part of the collection and transfer of records.

Implement effective communication strategies by:

- Using plan language and offering non-English language assistance where appropriate.
- Encouraging contact through plan/plan sponsor websites and toll free numbers.
- Building steps into the employer and plan onboarding and enrollment processes for new employees, and exit processes for separating or retiring employees, to confirm or update contact information, confirm information needed to determine when benefits are due and correctly calculate the amount of benefits owed, and advise employees of the importance of ensuring that the plan has accurate contact information at all times.
- Communicating information about how the plan can help eligible employees consolidate accounts from prior employer plans or rollover IRAs.
- Clearly marking envelopes and correspondence with the original plan or sponsor name for participants who separated before the plan or sponsor name changed, for example, during a corporate merger, and indicating that the communication relates to pension benefit rights.

Continued on page 13 ⟶

Conduct missing participant searches by:

- Checking related plan and employer records for participant, beneficiary and next of kin/emergency contact information. While the plan may not possess current contact information, it is possible that the employer's payroll records or the records maintained by another of the employer's plans, such as a group health plan, may have more up-to-date information. If there are privacy concerns, the person engaged in the search can request that the employer or other plan fiduciary forward a letter from the plan to the missing participant or beneficiary.
- Checking with designated plan beneficiaries (e.g., spouse, children) and the employee's emergency contacts (in the employer's records) for updated contact information; if there are privacy concerns, asking the designated beneficiary or emergency contact to forward a letter to the missing participant or beneficiary.
- Using free online search engines, public record databases (such as those for licenses, mortgages, and real estate taxes), obituaries, and social media to locate individuals.
- Using a commercial locator service, a credit-reporting agency, or a proprietary Internet search tool to locate individuals.
- Attempting contact via United States Postal Service ("USPS") certified mail, or private delivery service with similar tracking features if less expensive than USPS certified mail, at the last known mailing address.
- Attempting contact via other available means such as email addresses, telephone and text numbers, and social media.

Document procedures and action by:

- Reducing the plan's policies and procedures to writing to ensure they are clear and result in consistent practices.
- Documenting key decisions and steps taken to implement policies.
- For plans using TPAs to maintain records and send participant communications, ensuring that the record keepers are performing all agreed upon services and working with them to correct any issues in their practices.

The DOL also clarified that "not every practice [above] is necessarily appropriate for every plan" and that the specific steps taken to locate missing participants may vary due to "facts and circumstances particular to a plan and participant." Therefore, responsible plan fiduciaries will need to consider what missing participant practices "will yield the best results in a cost effective manner for their plan's particular population," given the size of the benefit to be paid and the cost of the search efforts.

If you have questions about the missing participant guidance or the compliance obligations created by the guidance, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

DOL Compliance Assistance Release 2021-01; EBSA FAB 2021-01

IRS Issues Final Regulations Regarding Excise Tax on Excess Compensation Under Code Section 4960 from page 11

and its related ATEOs exceeding 50% of his or her total hours worked for the ATEO and all of its related organizations for the current year and the preceding year. In addition, no related organization that paid remuneration to the individual may provide paid services to the ATEO, any related ATEOs, or any taxable related organizations controlled by the ATEO and/or related ATEOs.

Remuneration

In the case of remuneration other than regular wages (e.g., deferred compensation), the proposed regulations provided that the amount of remuneration treated as paid by the employer is generally the present value of such remuneration that vested during the applicable year. The final regulations clarify that if the amount of this remuneration is scheduled to be actually or constructively paid within 90 days of vesting, the employer may instead use the future amount that will be paid.

If you have questions about the impact of these new excess compensation regulations, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

CAA establishes cost sharing requirements and the amounts and time periods by which a plan must pay providers.

- *Independent Dispute Resolution Process for Determining Out of Network Rates*. Federal agencies must issue regulations to implement a new independent dispute resolution process by December 28, 2021 which health plans will use to determine the amount payable to certain out of network providers (including air ambulances) for services when the plan and provider cannot reach an agreement.
- *In Network and Out of Network Cost Transparency on ID Cards*. Health plans must include deductibles and out of pocket maximum limitations on participant insurance ID cards, as well as a telephone number and website where participants may seek consumer assistance information.
- *Advanced Explanation of Benefits*. Health plans must provide participants with information about their scheduled services, such as the in network status of the provider, the contracted costs, and estimates of plan and participant financial responsibility.
- *Ensuring Continuity of Care for Serious and Complex Conditions*. Health plans must satisfy new continuity of care requirements for patients who are receiving specified types of care if an in network provider terminates its relationship with a plan or the plan's benefits with respect to a provider are terminated.
- *Price Comparison Tools*. Health plans must offer price comparison guidance by telephone and an Internet price comparison tool that allows a price and cost sharing comparison of in network provider services.
- *Provider Directories*. Health plans must maintain a public website that contains a list of in network providers/facilities with directory information and establish a process to verify and update provider directory information.
- *Reliance on Provider Information*. Participants may be charged only in network cost sharing and deductible amounts for the furnished item or service if they are erroneously informed that a provider or facility is in network.
- *Balance Billing Disclosures*. Health plans must post and include on their EOBs a plain language statement regarding the prohibition on balance billing in certain circumstances.
- *Mental Health and Substance User Disorder Benefits*. Health plans must perform and document a comparative analysis of the design and application of the plan's mental health, substance use disorder, and medical/surgery nonquantitative treatment limitations and, by February 10, 2021, make this analysis available to federal regulators, upon request.
- *Reporting on Health Care and Pharmacy Benefits and Drug Costs*. By December 28, 2021, and not later than June 1 each year thereafter, a health plan must report to federal regulators detailed information relating to its benefits and prescription drug claims and costs.
- *Eliminating Contractual "Gag Clauses."* Effective December 28, 2021, a health plan cannot enter into an agreement which offers access to a network of providers if that contract directly or indirectly restricts the plan from providing certain information to participants, plan sponsors, or business associates.
- *New Disclosures of Direct and Indirect Broker and Consultant Compensation*. Effective December 28, 2021, consultants and brokers must disclose in writing specific detailed information relating to their services and direct and indirect compensation.

Dependent Care and Health FSAs

These changes are optional, so an employer is not required to adopt them. If utilized, amendments will be required.

- *Post Termination Health FSA Reimbursements (Health FSAs only)*. A health FSA may allow an employee who ceases participating in the FSA during 2020 or 2021 to receive reimbursements from unused contributions through the end of the plan year in which such participation ceased (including any grace period).
- *Special Carryforward Rules (for Dependent Care FSAs only)*. The CAA temporarily permits dependent care FSAs to (a) permit participants to carry over unused amounts from one plan year to the next, and (b) allow participants to receive dependent care reimbursements for qualifying children who turned age 13 during the COVID 19 pandemic and use those amounts in the following plan year until the child turns age 14.
- *Carryovers*. The CAA temporarily permits dependent care and health FSAs to allow any unused 2020 dollars to be used in 2021 and any unused 2021 dollars to be used in 2022.

New HHS Interpretation of Section 1557 Expands Plan Sponsor Obligations from page 3

Civil Rights has not investigated any claims of discrimination based on gender identity for approximately five years.

The Department of Health and Human Services is expected to initiate official rulemaking proceedings in 2022.

Challenges to Interpretation

The May 10, 2021 announcement affirmed that the Office for Civil Rights will comply with the Religious Freedom Restoration Act ("RFRA") and all other legal requirements. Soon after the announcement, district courts in North Dakota and Texas granted permanent injunctive relief from the provisions of or coverage of "gender transition" procedures to religious organizations. The religious organizations (including a Catholic hospital association, a Christian health care professional association, and a Catholic nonprofit providing health care) contended that were they made to comply with the new Section 1557 scheme, they would suffer "irreparable injury." Further, the religious organizations asked only for a permanent injunction, meaning that the HHS could continue to interpret the rule as it applies to others, but the religious organizations would not be made to suffer. The district courts agreed that to subject the religious organizations to the new Section 1557 scheme would force them to perform gender transition processes contrary to their religious beliefs — "a quintessential irreparable injury." See *Franciscan Alliance v. Becerra* (N.D. Tex. 2021).

Next Steps

The new Section 1557 interpretation requires that individuals be treated equally—regardless of gender—not only in the health care they receive but also in the health care they have access to. This means that the ACA effectively prohibits the denial of health care or health coverage based on an individual's gender, gender identity, and sexuality. Health programs and activities must also treat individuals consistent with their gender identity. Recent Section 1557 claims brought include allegations that an insurer's policy that fertility treatments be covered after one year of "trying" to get pregnant discriminates against same sex couples as well as allegations that a health care provider refused to use the correct pronouns and otherwise treat an individual in accordance with their gender identity.

While Section 1557 applies only to "covered entities," e.g., entities that operate a health program or activity that receives federal financial assistance (including credits, subsidies, or contracts of insurance), Section 1557 cases may still be referred to the Equal Employment and Opportunity Commission ("EEOC").

Practically, sponsors of health and welfare plans should:

- Review written policies and procedures to ensure that they comply with Section 1557 and do not specifically exclude benefits based on a participant's sex.
- Provide notice to plan participants informing them of their rights, including their rights under the new Section 1557 interpretations.
- Ensure that individuals are properly trained and educated on Section 1557.
- Work with service providers to ensure that plans are properly interpreted and applied to comply with Section 1557.

For more on Section 1557, including whether your health and welfare program qualifies as a covered entity, review of your current plan and policies, and guidance on actions to take to ensure compliance with Section 1557, do not hesitate to reach out to our Health and Welfare experts.

- *Extended Grace Periods*. A dependent care or health FSA may have a 12 month grace period for the 2020 and 2021 plan years. The extended grace period provides participants a longer period of time to incur claims that may be reimbursed from an FSA for the applicable plan year.
- *Changing FSA Election Amounts*. For plan years ending in 2021, a dependent care or health FSA may allow an employee to prospectively change, for any reason, the amount the employee elected to contribute to the FSA.

Employer Payments of Student Loans

The CAA extends the time period to January 1, 2026 (from January 1, 2021) for employers to use an educational assistance program to make certain tax free payments of employees' qualifying education loans.

Retirement Plan Provisions

The CAA provides several forms of pandemic and disaster relief for retirement plans, as well as a few technical corrections, including:

- *Deductibility of Retirement Plan Contributions*. The CAA affirms that retirement plan contributions are deductible even if they are financed by Paycheck Protection Program ("PPP") loan proceeds.
- *Partial Plan Termination Relief*. The CAA permits a company to avoid the 100% vesting requirement associated with a partial plan termination if the plan covers at least 80% as many participants on March 31, 2021 as were covered by the plan on March 13, 2020.
- *Section 420 Transfers*. Employers that had elected to make a "qualified future transfer" under Section 420(f) of the Internal Revenue Code may elect, by December 31, 2021, to terminate the transfer and revert the unused funds to the defined benefit plan, with certain conditional responsibilities spelled out in the CAA.
- *Disaster Relief*. The CAA provides optional relief for non coronavirus related disasters (such as storms or fires) that occurred between January 1, 2020 and February 25, 2021. The relief allows affected participants in declared disaster areas to take qualified distributions of up to $100,000 in aggregate from 401(k), 403(b), 457(b), or money purchase plans without tax penalties and with the option to repay the distributed amounts. Larger loan limits and loan payment delays also are permissible.

Summary of Selected Employee Benefit Related Limits

Click here to download a detailed checklist.

	2022
Elective Deferral Limits[1]	
401(k), 403(b) and SEPs	20,500
457 plans	20,500
SIMPLE IRAs and 401(k)s	14,000
Catch-up Contributions[1]	
401(k), 403(b), 457 and SEPs	6,500
SIMPLE IRAs and 401(k)s	3,000
Maximum Annual Compensation[1]	
401(a)(17)	305,000
415 Maximum Annual Additions[1]	
Defined benefit plan dollar limit	245,000
Defined contribution plan dollar limit	61,000
Highly Compensated Employees[1]	
414(q)	135,000
Key Employees (Top Heavy)[1]	
Officers	200,000
1% owner	150,000
Employee Stock Ownership Plans[1]	
Five-year distribution threshold	1,230m
Step up	245,000
IRAs[1]	
Annual contribution limit	6,000
Catch-up contributions	1,000
PBGC[2]	
Annual maximum guaranteed benefit	74,455
Transportation Fringe Benefits[3]	
Employer-provided parking (monthly)	280
Mass transit pass & vanpool (monthly)	280
Social Security[4]	
Taxable wage base	147,000
Health Savings Accounts[5]	
Individual contribution limit	3,650
Family contribution limit	7,300
Catch-up contributions	1,000
Health FSAs[3]	
Employee contribution limit	2,850

[1] IRS Notice 2021-61

[2] PBGC Maximum Monthly Guarantee Tables available at PBGC.gov (SLA, age 65)

[3] Rev. Proc. 2021-45

[4] SSA Press Release (10/13/2021)

[5] Rev. Proc. 2021-25

Fifth Circuit Decision Highlights Importance of Compliance with ERISA Notice Requirements

The Fifth Circuit Court of Appeals recently vacated a Louisiana District Court's dismissal of a benefits claim, in a case that highlights the importance of strictly complying with ERISA's notice requirements when deciding benefits claims.

Facts of the Case

Mr. Hamann was a retired participant in the Building Trades United Pension Trust, a multiemployer defined benefit pension plan (the "Plan"). When he died, his wife was his surviving beneficiary. She applied for the post-retirement survival benefits due to her under the Plan, and her monthly annuity application was approved by the Plan on March 1, 2017. She then sought to convert her monthly benefit to a lump sum payment. The Plan's conversion form stated that the form must be completed and returned "by April 5, 2017 to receive the [lump sum] payment on May 1, 2017." The Plan received Mrs. Hamann's request on April 4, 2017, before the form's stated deadline, but Mrs. Hamann died before the scheduled May 1 payment was made.

Mrs. Hamann's estate administrator inquired about the May 1 lump sum payment, but the Plan responded in April 2017 that no benefits were owed to Ms. Hamann because she died before the benefit payment date. Approximately eight months later, the estate administrator sent a letter to the Plan demanding payment of the lump sum benefit. However, in March 2018, this demand was rejected because the demand was not made within 60 days of the April 2017 denial. The administrator did not appeal that determination, and instead filed suit.

District Court Ruling

The district court dismissed all five of the plaintiff's ERISA claims with prejudice, in part because the plaintiff had failed to exhaust her administrative remedies before filing suit. In general, a claimant must exhaust the administrative remedies laid out in the benefits plan before pursuing legal remedies. The Plan conceded that its April 2017 letter did not substantially comply with ERISA's notice requirements, but argued that its March 2018 letter *did* substantially comply with ERISA's notice requirements, curing its prior failure. The district court agreed, finding that the plaintiff was not excused from failing to appeal within 60 days of receiving the March 2018 letter.

Fifth Circuit Ruling

On appeal, the Fifth Circuit vacated the dismissal of the action with instructions to the district court to remand the claim to the Plan so that it could evaluate the merits of the plaintiff's pension claim. Although claimants seeking benefits from an ERISA plan are required to first exhaust administrative remedies before bringing suit, a claimant is excused from exhausting administrative remedies and is deemed to have exhausted them if a plan's administrator fails to establish or follow claims procedures consistent with ERISA's requirements.

The circuit court agreed that the Plan's April 2017 letter did not substantially comply with ERISA's notice requirements, but held that this failure should have excused the plaintiff from timely exercising her appeal rights. The timing requirements in ERISA are clear, and nothing in the ERISA regulations allows the Plan to cure its defective denial notice 242 days late. However, even if a cure period were applicable, fairness does not permit excusing the Plan's mistakes while simultaneously holding the plaintiff to "every jot and tittle" of the timing requirements.

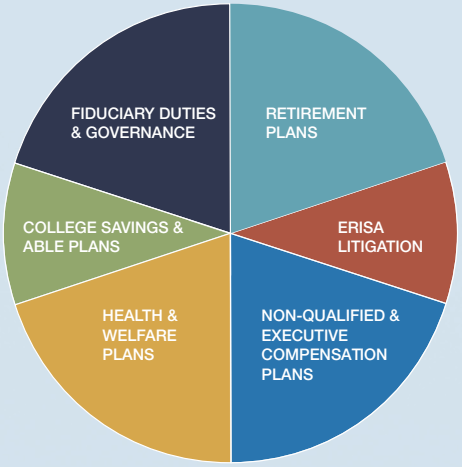
The circuit court also held that the March 2018 letter failed to substantially comply with ERISA's notice requirements for several reasons. First, it did not describe the Plan's voluntary appeal procedures. It also actively discouraged plaintiff from seeking administrative review, stating that her request for review was untimely and that she could not seek judicial review; this created a reasonable ambiguity as to whether or not appeal rights were actually available. Finally, the letter was not provided within "5 days after the benefit determination," as required by ERISA. Therefore, the plaintiff should have been excused from exhausting her administrative remedies with respect to both of the Plan's letters.

If you need assistance in creating or modifying your plan's claims and appeals procedures to conform to the requirements of ERISA, or need advice regarding ERISA's statutory and regulatory requirements, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

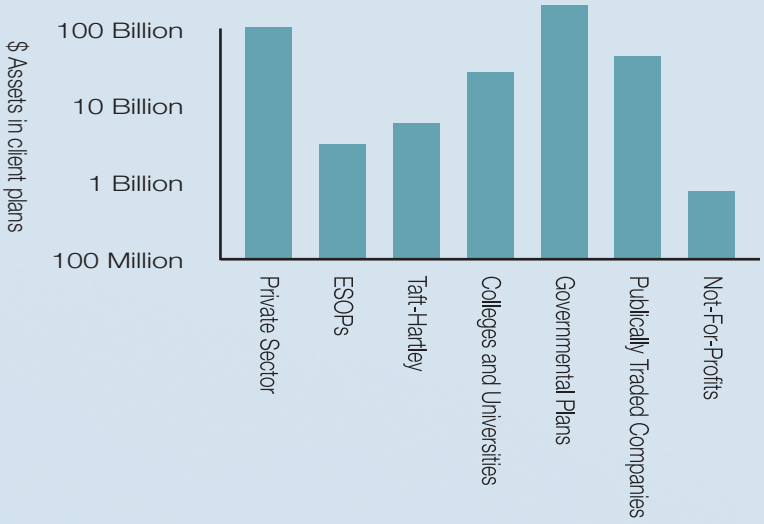
Theriot v. Building Trades United Pension Trust Fund, 2021 WL 955152 (5th Cir. Mar. 12, 2021)

About Us

What We Do



Who We Represent



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2021 Client Alerts: Click to follow link

Consolidated Appropriations Act, 2021 Makes Major Employee Benefits Changes

Takeaways from the Final Code Section 162(m) Rules on Executive Pay Caps

Inoculating Against Risk: Issues to Consider With COVID-19 Vaccination Incentives

DOL and IRS Clarify Duration of Tolled EB Deadlines

American Rescue Plan Act Ushers In More Benefits Changes

Settlement of Blue Cross Blue Shield Litigation Requires Action

IRS Releases COBRA Subsidy Guidance

Updated IRS Program Offers More Flexibility in Retirement Plan Corrections

DOL Signals More Favorable View of ESG Funds in Retirement Plans

Deadlines Fast Approaching for Health Plans to Comply with the Consolidated Appropriations Act, 2021 and Transparency Rule

New Illinois Disclosure Requirement for Health Plans

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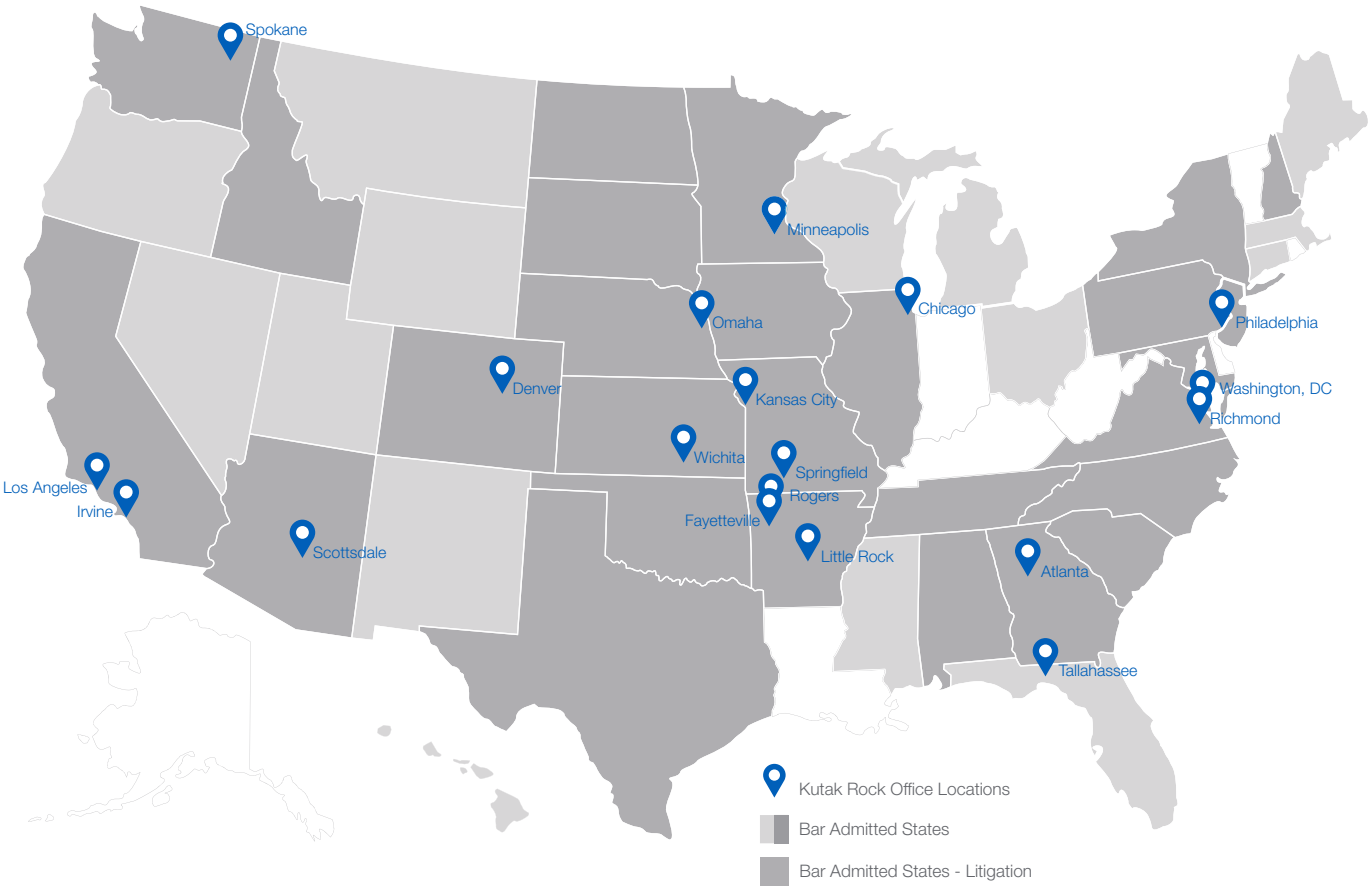

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