ISSUES
EMPLOYEE BENEFITS

KUTAKROCK

YEAR END 2022

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What's Inside

U.S. Department of Labor Issues Cybersecurity Guidance for Plan Sponsors, Recordkeepers, and Plan Fiduciaries

The Internet continues to be an ever-more-prevalent part of our lives; 90% of people today complete some or all of their financial transactions online. However, as online financial transactions increase, so do internal and external security threats. Even a relatively small retirement plan can present an optimal target opportunity for criminals, given the amount of assets involved and the number of potential data sources (e.g., participants, insurers, plan administrators, custodians, trustees) and entry points (e.g., phones, laptops, servers). A single successful attack can be devastating.

ERISA requires plan fiduciaries to take appropriate precautions to mitigate these risks. Consequently, the Employee Benefits Security Administration division of the U.S. Department of Labor ("DOL") has, for the first time, released cybersecurity best practices to assist prudent plan sponsors, plan fiduciaries, and recordkeepers in protecting participant data. This guidance builds on the DOL's existing regulations concerning the electronic records of plan participants and beneficiaries. Because cybersecurity is likely to be an emerging enforcement focus for the DOL in coming years, this article highlights steps that plan sponsors can take to safeguard the retirement benefits and personal information of their plans' participants.

(CONTINUED ON PAGE 2)

SECURE Act and CARES Act Amendment Deadlines Extended

The IRS deadline to amend most retirement plans to adopt SECURE Act and CARES Act provisions is now **December 31, 2025**. This extension applies to qualified retirement plans, non-governmental plans, 403(b) plans, and IRAs. The deadline for governmental plans is 90 days after the end of the third legislative session of the body that has plan amendment authority that begins after **December 1, 2023**. Note, however, the amendment deadline for non-governmental 457(b) plans is still **December 31, 2022**.

(CYBERSECURITY GUIDENCE CONTINUED FROM PAGE 1)

Cybersecurity Best Practices

According to the DOL's best practices guidance[1], responsible plan fiduciaries will take the following steps to mitigate their cybersecurity risks:

1. **Have a formal, well-documented cybersecurity program** that fully implements information security policies, procedures, guidelines, and standards to protect the security of the IT infrastructure and data stored on the system. Any adopted policies should be approved by senior leadership and reviewed at least annually.
2. **Conduct prudent risk assessments**, at least annually, that identify, estimate, and prioritize information system risks and describe how such risks will be mitigated or compartmentalized.
3. **Have a reliable, annual third-party audit of security controls** so that fiduciaries have a clear, unbiased report of existing risks, vulnerabilities, and weaknesses.
4. **Clearly define and assign information security roles and responsibilities**. Generally, the program will be managed at the senior executive level (e.g., CIO) and executed by qualified personnel.
5. **Have strong access control procedures**, which include authentication and authorization components.
6. **Ensure that any assets or data stored in a cloud or managed by a third-party service provider are subject to appropriate security reviews and independent security assessments**.
7. **Conduct periodic cybersecurity awareness training** and update the training as needed to reflect risks from the most recent annual risk assessment.
8. **Implement and manage a secure system development life cycle ("SDLC") program**, including penetration testing, code review, and architecture analysis.
9. **Have an effective business resiliency program addressing business continuity, disaster recovery, and incident response**.
10. **Encrypt sensitive data, stored and in transit** by implementing the most current standards for use of encryption keys, message authentication and hashing.
11. **Implement strong technical controls in accordance with best *security practices***, such as automatic updates, system hardening, routine backups, and use of antivirus software and firewalls.
12. **Appropriately respond to any past cybersecurity incidents** by adequately investigating the incident, informing law enforcement, insurers and affected participants, and fixing the problems that led to the breach.

1. https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/best-practices.pdf.
2. https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/tips-for-hiring-a-service-provider-with-strong-security-practices.pdf.

Best Practices for Hiring Service Providers

Responsible plan fiduciaries have an obligation to ensure proper mitigation of *all* potential cybersecurity risks, including any cybersecurity risks from vendors or service providers that use or maintain participant data. Plan fiduciaries should hire service providers that follow strong cybersecurity practices.[2] Therefore, any prudent process for hiring service providers will include:

1. **Asking about the service provider's information** security standards, audit results, practices, and policies, including how these compare to the industry standards adopted by other financial institutions.
2. **Asking how a service provider validates its practices**, and what levels of security standards it has met and implemented. Vendor contracts should give plan fiduciaries the right to review audit results demonstrating compliance with the standards.
3. **Evaluating the service provider's track record in the industry**, including public information regarding information security incidents, other litigation, and legal proceedings related to vendor's services.
4. **Asking whether the service provider has experienced past security breaches**, what happened, and how the service provider responded.
5. **Confirming the service provider has insurance policies that would cover losses caused by cybersecurity and identity theft breaches** (including breaches caused by internal threats, such as misconduct by the service provider's own employees or contractors, and breaches caused by external threats, such as a third party hijacking a plan participant's account).

When reviewing the contracts with a service provider, plan fiduciaries should verify that the contract requires *ongoing* compliance with cybersecurity and information security standards. Provisions that limit the service provider's responsibility for I.T. security breaches should be rejected. In addition, vendor contracts should include cybersecurity protections that protect the plan and its participants, such as insurance policies, information security reporting obligations, information sharing and confidentiality provisions, cybersecurity breach notification requirements, and record retention/destruction protocols.

In addition to the above, fiduciaries should consider securing cyber security insurance to cover their retirement plan. Some fiduciary liability insurance policies cover cyber incidents, but not all policies provide the same level of protection.

If you have questions about the cybersecurity 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.

Employee Benefits Security Administration
News Release (No. 21-358-NAT)

New Employees

Rachel A. Loscheider is an associate in the Minneapolis office and joined the firm in May. Prior to joining Kutak Rock, Rachel worked at a law firm in St. Paul, Minnesota, where she advised long-term care businesses. Rachel is a 2020 graduate of Mitchell Hamline School of Law, where she was an Associate of the Mitchell Hamline Law Review and obtained certifications in Health Care Compliance and Health Law. Prior to law school, Rachel graduated from the College of Saint Scholastica in Duluth, Minnesota, double majoring in psychology and exercise physiology. In her free time, Rachel enjoys exploring the outdoors, experimenting with new recipes, and going on walks with her husband and chocolate lab, Clyde.

Emma Franklin is an associate in the Omaha office and joined the firm in September, after clerking with the Employee Benefits practice group during the 2020 and 2021 summer sessions. Emma is a 2022 graduate of Nebraska College of Law, where she served as an Executive Editor of the *Nebraska Law Review*. Prior to law school, Emma attended the University of Nebraska at Omaha, majoring in English and political science. In her free time, Emma enjoys board games, reading, and exploring new places and opportunities.

Peter Hayden-Roy is a law clerk in the Omaha office and a 2L at the University of Nebraska College of Law. Peter grew up in Lincoln, Nebraska and went to school at Valparaiso University, where he received B.A.s in creative writing and German. This summer, Peter gained hands-on experience supporting the partners and associates in the Employee Benefits practice group, with work spanning a range of topics. Peter will rejoin the firm as a clerk next summer. In his free time, Peter enjoys sports, chess, and writing short stories.

Getting the 409A Valuation Right for Stock Rights

Section 409A of the Internal Revenue Code ("Section 409A") regulates the taxation of nonqualified deferred compensation, including stock options and stock appreciation rights ("Stock Rights"). In particular, a Stock Right granted with an exercise price that is less than the grant date fair market value is considered deferred compensation subject to Section 409A; such a Stock Right, if designed to give the holder discretion over the exercise date, would likely violate Section 409A and result in significant penalties on the holder. Accordingly, it is important for employers to grant Stock Rights at fair market value in order to exempt them from being deemed deferred compensation under Section 409A.

Section 409A specifically outlines acceptable methods for determining the fair market value of stock that is readily tradable on an established securities market. Such methods include the last sale price before the grant, the first sale price after the grant, the closing price on the trading day before the grant, the closing price on the trading day of the grant, the mean of the high and low prices on the trading day before the grant, and the mean of the high and low prices on the trading day of the grant.

With respect to stock not readily tradable on an established securities market, Section 409A sets forth three valuation safe harbors:

1. **Qualified Independent Appraiser Method**. A valuation is presumed reasonable if it is determined by a qualified independent appraiser no more than 12 months before the grant date.

2. **Illiquid Startup Method**. A valuation of a company that has conducted business for 10 years or less and is not reasonably expected to imminently undergo a change in control or a public offering is presumed reasonable if: (a) the valuation was performed within the past 12 months by a person with significant knowledge and experience or training in performing similar valuations; (b) the valuation is evidenced by a written report; and (c) the valuation considers the reasonableness factors identified above.

3. **Non-Lapse Restriction Method**. A valuation is presumed reasonable if it is based on a permanent transfer restriction that requires the transferee to sell the stock at a formula price (e.g., book value or a reasonable multiple of earnings) and such valuation is consistently used for both compensatory and non-compensatory purposes in all transactions in which the issuer is either the purchaser or seller of the stock.

Use of one of these safe harbor methods will result in the valuation being presumed reasonable. However, companies may also set fair market value through the "reasonable application of a reasonable valuation method." This is generally a facts and circumstances approach based on all available information material to the value of the company, including the value of the company's tangible and intangible assets, the present value of future cash flows, the market value of similar entities engaged in a substantially similar business, recent arm's-length transactions, and other relevant factors such as control premiums or discounts for lack of marketability. A valuation method is more likely to be deemed reasonable if it is used for other purposes that have a material economic effect on the company or its stockholders or creditors.

The consequences of failing to comply with Section 409A are severe. Setting the exercise price at fair market value generally exempts a Stock Right from Section 409A, but a non-compliant valuation could cost a Stock Right holder accelerated income tax recognition in the year of vesting, a 20% federal penalty tax, a possible state tax penalty, and premium interest. If you have any questions about valuing stock right grants under Section 409A, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

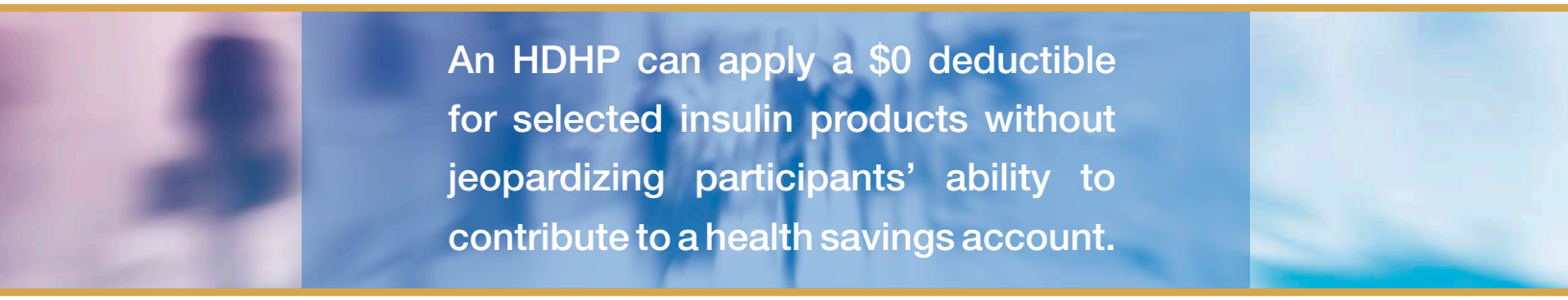
Expanding Insulin Coverage for High Deductible Health Plans

In August 2022 President Biden signed the Inflation Reduction Act ("IRA") into law. Effective for plan years beginning after December 31, 2022, the IRA allows a high deductible health plan ("HDHP") to cover selected insulin products without a deductible. This means that an HDHP can apply a $0 deductible for selected insulin products without jeopardizing participants' ability to contribute to a health savings account. For this purpose, "selected insulin products" means any dosage form (such as vial, pump, or inhaler) of any different type of insulin, including rapid-acting, short-acting, intermediate-acting, long-acting, and premixed insulin types.

Employers can amend their HDHPs to provide coverage of selected insulin products without a deductible. A summary of material modifications should be distributed informing participants and beneficiaries of the amendment. For self-insured health plans, the third-party administrator and stop-loss carrier should also be informed of the amendment.

The IRA will also allow Centers for Medicare & Medicaid Services to negotiate prescription drug costs with drug manufacturers and apply caps on certain drugs covered under Medicare Part D and Part B, including some insulin products. Insulin products subject to the caps will cost Medicare recipients no more than $35. This may result in employer-sponsored group health plans experiencing increased prescription costs as drug companies seek to offset losses from drugs subject to the Medicare price caps.

If you have questions about the expanded insulin product coverage options available under the IRA or need assistance in amending your HDHP to provide expanded insulin coverage, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.



Mixed Feelings About *Hughes v. Northwestern*

Almost one year has passed since the Supreme Court issued a decision in favor of participants in *Hughes v. Northwestern*; as expected, excessive fee lawsuits brought against plan sponsors under the Employee Retirement Income Security Act of 1974 ("ERISA") have not slowed down. In fact, we are on track for over 100 ERISA class action lawsuits in 2022! While the Supreme Court affirmed that offering some prudent investments within a menu of other investments does not, by itself, satisfy the duty of prudence, it clarified little else and instead emphasized application of a context-specific inquiry. In light of this guidance, results at the lower courts have been mixed. This article outlines several recent case results and their common themes.

Summary of *Hughes v. Northwestern*

Northwestern involved a class of participants in Northwestern University's 403(b) plan who alleged that plan fiduciaries breached their fiduciary duties by:

- causing the plan to pay excessive recordkeeping fees;
- providing too many investment options; and
- including expensive investment options where identical but cheaper options were available.

The lower courts dismissed the case, concluding that the participants failed to allege plausible ERISA violations. However, the Supreme Court reversed and remanded, stating that courts must use a context-specific inquiry to determine whether sufficient facts have been presented to support a breach of fiduciary duty claim. The Supreme Court also emphasized that there is not a single reasonable fiduciary decision in a given situation, but rather a *range* of reasonable decisions that depend on the circumstances.

No Time for Plan Sponsor Defenses

One month after the *Northwestern* decision, in *Lauderdale et al. v. NFP Retirement Inc. et al*., the Central District of California denied NFP's motion to dismiss participants' fiduciary breach claims. Citing *Northwestern*, the court concluded that participants need only *plausibly* allege a fiduciary breach to advance their case. Whether the claims will hold up after both parties have presented their evidence is immaterial when deciding an initial motion to dismiss. Similarly, the Ninth Circuit reversed the dismissals of participant claims in *Davis v. Salesforce* and *Kong v. Trader Joe's* after the *Northwestern* decision. In *Trader Joe's*, the Ninth Circuit explained that "taking the allegations as true, ***as we must at this stage***," Trader Joe's rationale for its fiduciary decisions is immaterial at the pleading stage. The Ninth Circuit was similarly dismissive of employer fiduciary explanations in *Salesforce*, concluding it was inappropriate to consider Salesforce's explanation for utilizing more expensive class shares at the pleading stage.

(MIXED FEELINGS ABOUT *HUGHES V. NORTHWESTERN* CONTINUED ON PAGE 5)

(MIXED FEELINGS ABOUT *HUGHES V. NORTHWESTERN* CONTINUED FROM PAGE 4)

Participant Allegations Must Still Be Supported by the Appropriate Context

Not every court is willing to accept participant allegations at face value. A three-judge panel in the Sixth Circuit held, in *Smith v. CommonSpirit Health*, that whether an ERISA excess fee claim is plausible depends on many factors, including "common sense and the strength of competing explanations for a defendant's conduct." Dismissing the participants' claims, the Sixth Circuit panel noted that allegations of fiduciary breach require "evidence" of actual imprudence, including meaningful benchmarks and "context" enough to move the allegations from "possibility to plausibility."

In *Albert v. Oshkosh Corporation*, participants alleged that allowing some of the plan's investment options and service providers to charge excessive fees was a breach of the plan sponsor's fiduciary duties. Affirming the lower court's dismissal, the Seventh Circuit concluded that Northwestern did not require fiduciaries to regularly solicit bids from service providers and that a mere allegation that the plan paid higher service provider fees without more context (e.g., a comparison of fees charged by similar service providers) is not enough to plausibly allege a breach of fiduciary duty. Citing *Oshkosh*, an Illinois district court granted a plan sponsor's motion to dismiss in *Baumeister v. Exelon Corp*. because the participant did not support the allegations of fiduciary breach with context-specific facts showing a breach occurred, like a comparison of services offered by the lower-cost service providers, or demonstrating that investment benchmarks are appropriate comparators for challenging higher-priced investments.

Mixed Feelings on Higher-Priced Funds

Goodman v. Columbus Regional Hospital System was another excessive fee suit decided shortly after the *Northwestern* decision. The Georgia District Court explicitly cited *Northwestern* in its denial of the motion to dismiss, noting the Supreme Court's "suggestion" that fiduciary breach allegations based on the offering of higher-priced funds instead of identical but cheaper funds is plausible enough to defeat a motion to dismiss. However, in *Oshkosh*, the Seventh Circuit confirmed that ERISA does not require a fiduciary to choose the cheapest possible fund, so the mere availability of a cheaper fund is, without more, insufficient to sustain a fiduciary breach allegation. And, citing *Smith*, the Seventh Circuit reiterated that there are many reasons a plan sponsor may elect to offer a more expensive, actively-managed fund over a less expensive, passively-managed fund.

Next Steps

While decisions at the courts are still mixed, there are steps plan sponsors can take to mitigate their litigation risk. For instance:

- Regularly review and benchmark investment fund performance, investment expenses and service provider services and fees. In situations where the plan does not utilize the cheapest investment or service provider, document the rationale for the decision. Be very careful in documenting the decision as it will be discoverable in litigation.
- Regularly review and follow the plan's investment policy statement and act with respect to funds that fail to meet its criteria.
- Regularly review the plan's investment menu and adjust as needed. Plan sponsors have an obligation to offer a diverse menu of investment options but, as *Northwestern* affirmed, plan sponsors cannot simply offer prudent investment options alongside imprudent options and satisfy their fiduciary duties. Likewise, plan sponsors cannot rely on a brokerage window alone to satisfy their duties.
- Regularly reviewing service provider compensation and understanding what services are being included in fees, along with regular benchmarking, can confirm that the fees for services provided are competitive.

If you have questions about actions you can take to mitigate fiduciary risk in the wake of the *Northwestern* decision and its progeny, do not hesitate to reach out to the Kutak Rock Employee Benefits and Executive Compensation practice group.

Hughes v. Northwestern, 595 U.S. ____ (2022).

2023 Cost of Living Adjustment Chart

	2016	2017	2018	2019	2020	2021	2022	2023
Annual Elective Deferral Limits[1]								
401(k), 403(b) and SEPs	18,000	18,000	18,500	19,000	19,500	19,500	20,500	**22,500**
457 plans	18,000	18,000	18,500	19,000	19,500	19,500	20,500	**22,500**
SIMPLE IRAs and 401(k)s	12,500	12,500	12,500	13,000	13,500	13,500	14,000	**15,500**
Catch-up Contributions (≥ age 50)[1]								
401(k), 403(b), 457 and SEPs	6,000	6,000	6,000	6,000	6,500	6,500	6,500	**7,500**
SIMPLE IRAs and 401(k)s	3,000	3,000	3,000	3,000	3,000	3,000	3,000	**3,500**
Maximum Annual Compensation[1]								
401(a)(17)	265,000	270,000	275,000	280,000	285,000	290,000	305,000	**330,000**
415 Maximum Annual Additions[1]								
Defined benefit plan dollar limit	210,000	215,000	220,000	225,000	230,000	230,000	245,000	**265,000**
Defined contribution plan dollar limit	53,000	54,000	55,000	56,000	57,000	58,000	61,000	**66,000**
Highly Compensated Employees[1]								
414(q)	120,000	120,000	120,000	125,000	130,000	130,000	135,000	**150,000**
Key Employees (Top Heavy)[1]								
Officers	170,000	175,000	175,000	180,000	185,000	185,000	200,000	**215,000**
1% owner	150,000	150,000	150,000	150,000	150,000	150,000	150,000	**150,000**
Employee Stock Ownership Plans[1]								
Five-year distribution threshold	1,070m	1,080m	1,105m	1,130m	1,150m	1,165m	1,230m	**1,330m**
Step up	210,000	215,000	220,000	225,000	230,000	230,000	245,000	**265,000**
IRAs[1]								
Annual contribution limit	5,500	5,500	5,500	6,000	6,000	6,000	6,000	**6,500**
Catch-up contributions (≥ age 50)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**1,000**
PBGC[2]								
Monthly maximum guaranteed benefit	5,011.36	5,369.32	5,607.95	5,607.95	5,812.50	6,034.09	6,204.55	**6,750.00**
Annual maximum guaranteed benefit	60,136	64,432	65,045	67,295	69,750	72,409	74,455	**81,000**
Transportation Fringe Benefits[3]								
Employer-provided parking (monthly)	255	255	260	265	270	270	280	**300**
Mass transit pass & vanpool (monthly)	255	255	260	265	270	270	280	**300**
Social Security[4]								
Taxable wage base	118,500	127,200	128,400	132,900	137,700	142,800	147,000	**160,200**
Health Savings Accounts[5]								
Individual contribution limit	3,350	3,400	3,450	3,500	3,550	3,600	3,650	**3,850**
Family contribution limit	6,750	6,750	6,900	7,000	7,100	7,200	7,300	**7,750**
Catch-up contributions (≥ age 55)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**1,000**
Health FSAs3								
Employee contribution limit	2,550	2,600	2,650	2,700	2,750	2,750	2,850	**3,050**

Sources:
[1] IRS Notice 2022-55.
[2] PBGC Maximum Monthly Guarantee Tables available at PBGC.gov (SLA, age 65).
[3] Rev. Proc. 2022-38.
[4] SSA Press Release (10/13/2022).
[5] Rev. Proc. 2022-24; 26 U.S.C. § 223(b)(3)(B).

Identifying Whether Your Severance Plan Is an ERISA Plan and Understanding ERISA's Consequences

Many companies with severance "plans" have considered the employment law implications of such plans. However, fewer employers have considered the employee benefit implications that can apply to severance plans, in part because severance plans are subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in limited circumstances. It is important to identify when ERISA applies: an employer that maintains a severance plan that is subject to ERISA but fails to follow ERISA's requirements may be subject to potential penalties, including monetary and even criminal penalties.

Among other things, ERISA defines an employee benefit plan as "any plan, fund, or program…established or maintained by an employer … for the purpose of providing for its participants or their beneficiaries…any benefit described in Section 186(c)..." Among the benefits described in Section 186(c) are severance benefits.

Prior cases provide that whether a severance plan fits the definition of "employee benefit plan" above is based on the facts and circumstances of the plan and how the plan is designed and administered. The main factors in determining whether the facts and circumstances indicate the severance plan is subject to ERISA are:

- Whether the employer is required to exercise discretion in determining the eligibility to receive severance benefits; and
- Whether the severance payments are paid based on an "ongoing administrative scheme." Factors for determining whether there is an ongoing administrative scheme include:
    - whether the payments are one-time lump sums or continuous;
    - whether the employer undertook any long-term obligation with respect to the payments;
    - whether the severance payments come due upon the occurrence of a single, unique event or anytime the employer terminates employees; and
    - whether the severance arrangement under review requires the employer to engage in a case-by-case review of employees.
- ERISA imposes a number of requirements on severance plans subject to it, including (for example):
    - The plan must be in writing.
    - The plan must include a claims procedure.
    - The plan must file an annual Form 5500, unless the plan has fewer than 100 participants. To calculate the number of participants, the employer must count each employee who could be entitled to a benefit under the plan, not just those who actually receive a benefit.
    - Participants must be provided with a summary plan description of the plan.

Failing to follow ERISA's requirements can result in monetary penalties for failing to provide a summary plan description or failing to file annual reports, and criminal penalties for willful violations of ERISA's reporting and disclosing retirements.

It is not all doom and gloom, as there are several benefits a severance plan gains by being subject to ERISA. For example, with a written plan document, an employer can easily make changes to the plan, as opposed to being held to a "past practice" standard. In addition, employees will be subject to a claims procedure under which an employer's decision will be overturned only if the employer acts in an "arbitrary and capricious" manner. This is a significant benefit to employers if a dispute arises. ERISA litigation is also typically done in federal courts which tend to favor employers. For these (and other) reasons, some employers purposely choose to make their severance plans subject to ERISA.

As described above, a severance plan that is subject to ERISA will have significant impacts on plan administration and its treatment under the law. If you would like to review your severance plan for ERISA impacts, redesign your severance plan to avoid (or be subject to) ERISA, or set up a new severance plan, please contact a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

Failing to follow ERISA's requirements can result in monetary penalties for failing to provide a summary plan description or failing to file annual reports, and criminal penalties for willful violations of ERISA's reporting and disclosing retirements.

Send Your Employees Back to School With Education Benefits

With the cost of a higher education increasing each year, it is undeniable that education benefits are a highly desired benefit in the current job market. In a recent survey, 75% of employees stated they would feel more motivated in their current job if they had employer-provided education benefits and 73% of employee respondents believe that education benefits would make them feel more equipped at their current job.[1] Further, in another survey, 88% of Gen Z employees reported that they are more likely to recommend an employer that offered education benefits.[2]

Moreover, education benefits help not only employees but also employers. A study based on a large national employer's educational reimbursement program found that for every $1.00 the employer spent on its program, it not only got the $1.00 investment back but saved an additional $1.29 through reduced employee turnover and lower recruiting costs.[3] Likewise, another survey found that 81% of employees agreed that their employer's tuition assistance program makes them more likely to stay with the organization.[4] The why of education benefits seems clear, but what about the how? This article outlines the ways education benefits may be provided to employees and the benefits of each.

Section 127 Plans

Likely the most common way employers may provide education benefits are Section 127 Plans, which allow an employer to provide assistance to employees for educational expenses. If a plan meets the requirements of Code Section 127, then the money received by the employee is not included in the employee's gross income. The present annual limit on Section 127 tax-advantaged assistance is $5,250. For a Section 127 Plan to be qualified and receive tax advantages, it must fulfill several requirements, including:

- Maintaining a written plan document and providing notice to employees of the plan.
- Not discriminating in favor of highly compensated employees.
- Not requiring employees to choose between educational assistance and other remuneration.
- Providing benefits solely for educational assistance, including expenses for tuition, fees, books, and other supplies, and noting any expenditures should be substantiated by receipts or other documentation.
- Providing benefits for employees only, which may include retired, disabled, or laid-off employees, but does not include any spouses or other dependents.

Beyond these requirements, employers are given a great deal of latitude in designing their Section 127 educational assistance programs. For example, employers may require written notice from employees, certain grades, the attainment of a specific degree, or a certain amount of tenure with an employer to be eligible while still remaining qualified under Section 127 of the Code.

Section 117 Scholarships

Another way an employer may provide educational assistance is through a qualified scholarship program under Section 117 of the Code. Scholarships provide a way for employers to target educational assistance more directly and, as opposed to Section 127 plans, they can be provided to spouses and dependents of employees. However, like Section 127 plans, qualified scholarships must comply with a number of requirements or otherwise be included in the recipient's gross income. These requirements include:

- The scholarship cannot be contingent on a promise to work for the employer in the future.
- The selection committee for the scholarship must be composed of individuals independent and separate from the employer.
- The scholarship program must have identifiable requirements for eligibility and may not require more than three years of employment prior to any eligibility.
- Selection of scholarship recipients must be objective and based on standards unrelated to the employer's business or employment of any individual.
- The scholarship recipient must be free to use the scholarship on their choice of study.
- The scholarship program must be for the exclusive purpose of enabling recipients to obtain an education.
- The scholarship program must pass certain nondiscrimination requirements annually.

Section 117 Scholarships provide greater flexibility to whom educational assistance may be provided but does not provide assistance to every employee. Section 117 Scholarships may also provide a greater benefit beyond the Section 127 contribution limitations but, at the same time, narrow the field of individuals who actually receive such benefit.

(EDUCATION BENEFITS CONTINUED ON PAGE 9)

1. "Education Benefits Study, Executive Summary," *Bright Horizons* (October 14, 2020).
2. "2019 Working Learner Index," *Bright Horizons* (March 19, 2019).
3. "Cigna Realizes Return on Investment from Tuition Benefits, White Paper," Lumina Foundation (May 16, 2016).
4. "In Demand: Tuition Assistance," *Bright Horizons* (July 15, 2020).

(EDUCATION BENEFITS CONTINUED FROM PAGE 8)

529 Plan Contributions

Employers can also contribute to an employee's or employee's family member's account in a 529 Program. 529 Programs are tax-advantaged savings plans usually sponsored by states or state agencies and are authorized by Section 529 of the Internal Revenue Code. In order to gain the tax benefits of a 529 account, funds in a 529 account may be used only for qualified education expenses such as tuition, books, and room and board. Further, any contributions made to 529 accounts are deductible by employers as wages and compensation. While an employee may be taxed on these contributions (depending on specific state laws), an employer may contribute more than the Section 127 limitation. Further, some states, including Arkansas, Colorado, Illinois, Nebraska, Nevada, Wisconsin, and Utah, offer incentives to employers who provide contributions to their employees.

Education Benefits in the Future: SECURE 2.0 and Employer Matching

The proposed Securing a Strong Retirement Act of 2022 (SECURE 2.0) contains several novel employee benefits related provisions, including one that would allow companies to "match" an employee's student loan payments. Under SECURE 2.0, an employer would be permitted to match an employee's student loan payments as contributions to a qualified retirement plan. For example, if an employee forgoes deferrals in order to make student loan payments every month, an employer would still be able to provide the matching benefit. This provision would allow those employees with student loan debt burdens to pay off their loans while still saving for retirement. SECURE 2.0 is expected to pass during the lame duck session in December 2022.

Next Steps

If you have any questions about education benefits programs or would like assistance in determining what education benefits are best for your employees, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

Philadelphia Commuter Benefit

A new Philadelphia city ordinance effective December 31, 2022 requires employers with 50 or more "covered employees" to supply commuter benefits to such employees. Covered employees are those who performed an average of 30 hours of paid work per week in Philadelphia for the same employer over the last year. Thus, "covered employee" does not include new hires, volunteers, or unpaid personnel, such as interns.

Employers subject to the ordinance must offer at least one of the following commuter benefits to its covered employees:

- A transportation fringe benefit plan under Section 132(f) of the Code, which permits employees to elect to save money on a pre-tax basis to pay for mass transit expenses (such as a fare card or transportation in a commuter highway vehicle) or bicycle expenses;
- An employer-provided fare card with benefits equal to or greater than the maximum amount set out in Section 132(f)(2) of the Code; or
- A combination of the two options.

The City will investigate and attempt to mediate any complaints regarding non-compliant employers. The ordinance specifies that an employer that fails to comply with the ordinance after mediation will then receive a written warning, followed by imposition of fines that range from $150 to $300 per day for each day the employer remains non-compliant.

Affected employers should implement a commuter benefit that satisfies these rules or review an existing commuter benefit for compliance with the new requirements. If you are an employer in Philadelphia subject to this new ordinance, or have questions about commuter benefits in general, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

Target Date Fund Litigation Intensifies

With the explosive rise in excessive fee litigation against retirement plans and their fiduciaries, the threat of a lawsuit is a realistic one for most mid-sized and large retirement plans. Recently, however, some of the litigation involving the selection of "do-it-for-me" investment products such as target date funds and managed accounts has become increasingly complex. The takeaway from this litigation is that plan fiduciaries cannot merely look at fees for these products. They must also evaluate the history and track record of these products, the process for selection of underlying investments, and whether these products have been adopted by other plan fiduciaries or whether their plan is becoming a "guinea pig" for a novel and untested investment.

Northern Trust

Over the last two years, plan sponsors have faced costly litigation over the Northern Trust Focus Funds; this litigation demonstrates the need to review target date funds to ensure that plan fiduciaries are not adopting an untested product. Although the litigation included allegations related to fees, a significant part of the litigation focused on the fact that the plan sponsors adopted the funds when they had less than five years of performance data available. Subsequently, the funds underperformed 75%-90% of their peers. The plan fiduciaries also failed to take into account the relatively low adoption rates of the Northern Trust investments. One plan fiduciary implicated in these cases settled for $13.75 million in 2021, while the other lawsuits are ongoing.

Wells Fargo

Recent litigation against Wells Fargo also emphasizes the need to review both novel target date fund products and the nature of the underlying investments especially carefully. In April, Wells Fargo agreed to pay a $32.5 million settlement in connection with offering a proprietary target date fund product in its own plan. The lawsuit alleged that Wells Fargo mapped nearly $5 billion in participant assets to its own untested target date fund product as a means of "seeding" the product for marketing it to other plans. While proprietary funds in target date funds themselves are common and generally not problematic per se, plan fiduciaries should pay special attention to the use of proprietary products in newer product offerings.

NFP flexPATH

In recent years, vendors have expanded their offerings of custom target date products. While these products should be considered and offer some advantages compared to traditional target date funds, plan fiduciaries must review them carefully. In particular, the flexPATH litigation focuses on the "novel and untested" management style of the flexPATH product, as well as the selection process for the fund manager and the expertise of that manager. The litigation also raises the issue of unreasonable investment expenses that benefit NFP.

BlackRock

Finally, plaintiffs have filed at least nine lawsuits in July and August targeting passively managed BlackRock target date funds. These lawsuits, in contrast to the previous wave of lawsuits alleging that plan fiduciaries should have selected low-cost, passively-managed investments, allege that the plan fiduciaries who selected the BlackRock funds chased low fees at the expense of higher-performance investments. The complaints also allege that the plan fiduciaries in question should have selected target date funds with a "through" retirement glidepath, rather than a "to" retirement glidepath like that utilized by the BlackRock funds.

Although much of the litigation described above is ongoing, there are a few takeaways for plan fiduciaries. Merely reviewing fees and performance is not sufficient for target date funds. Plan fiduciaries should also be careful to evaluate new products in the target date fund marketplace and pay special attention to the utilization of proprietary funds in target date funds. While plan fiduciaries may want to consider custom target date fund products that are available to them, these products require special due diligence with respect to manager selection and methodology, fees, and utilization of proprietary products.

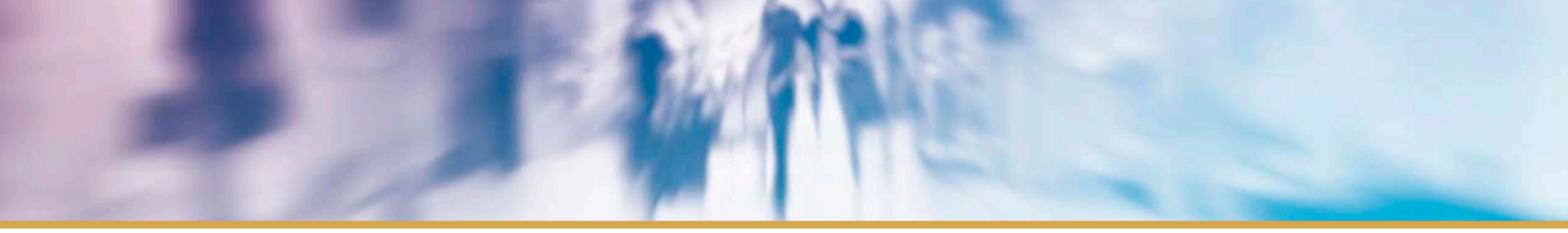
If you have questions about the trends in ERISA litigation or want more information about how to mitigate your litigation risks, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

NORTHERN TRUST

WELLS FARGO

flexPATH® STRATEGIES

BLACKROCK



Healthcare Cost Transparency Rules Already Affecting Hospital Pricing

In the United States, the single largest component of healthcare expenditures in recent years has been hospital spending. $1.3 trillion was spent at hospitals in 2020, but there are efforts to reduce this number. Recent years have seen a flurry of changes in healthcare transparency and reporting regulations, which are intended to increase price transparency for healthcare services, empower consumers and plan sponsors to make informed decisions, promote price competition among providers, and ultimately reduce the costs of healthcare. Two of these regulations, the Hospital Price Transparency Rule ("HPT") and the Transparency in Coverage Rule ("TiC") have now taken partial or full effect, and early data shows that they are already working to reduce hospital pricing.

Overview of Healthcare Cost Transparency Rules and Enforcement

HPT applies to hospitals, while TiC applies to non-grandfathered group health plans and health insurance issuers. However, the transparency requirements in the two rules are similar. Broadly speaking, HPT required each hospital operating in the United States to provide, by **January 1, 2021**, clear, accessible pricing information online about the standard charges for the items and services they provide, both (a) as a comprehensive machine-readable file with all items and services and (b) in a display of 300 shoppable services in a consumer-friendly format.

While all of HPT's provisions went into effect at the same time, TiC's implementation and enforcement has occurred in stages. By **July 1, 2022**, plans and issuers were required to publicly provide machine-readable files containing certain in-network and out-of-network pricing data. A third file with prescription drug cost information was also contemplated by TiC, but enforcement for this data file has been delayed until the regulators issue new regulations. Then, beginning on **January 1, 2023**, providers and issuers will be required to provide an Internet-based price comparison tool allowing an individual to receive a real-time estimate of their cost-sharing responsibility for 500 specific items and services covered by their plan. By **January 1, 2024**, the comparison tool must be updated to include all covered items and services.

Noncompliance is subject to civil enforcement action by the Centers for Medicare & Medicaid Services ("CMS"), with monetary penalties for hospitals of up to $300 (or up to $10 per bed) per day per violation, and penalties for TiC violations of up to $100 per day per violation, per person affected. CMS has already demonstrated its enforcement intent with relation to HPT. CMS began hospital audits in January 2021, shortly after HPT took effect; by October 2021 CMS had issued 335 warning notices and 98 requests for a corrective action plan to non-compliant hospitals, and by June 2022 CMS had fined two hospitals: Northside Hospital Atlanta ($883,180.00) and Northside Hospital Cherokee ($214,320.00). Each hospital had failed to post a consumer-friendly, searchable list of standard charges in a single machine-readable file. We expect CMS to follow a similar enforcement pattern and timeline with respect to TiC's requirements.

Early Data Shows Hospital Pricing Reductions

Hospital pricing data remains incomplete – one study conducted by PatientRightsAdvocate.org showed that only 5.6% of the 500 surveyed hospitals were in full compliance with all of HPT's requirements, although roughly 85% of the surveyed hospitals were partially compliant (i.e., the hospitals provided machine-readable files and/or price-estimator tools, but the files or tools were deficient in one or more respects). Despite these shortcomings, the early data shows that many plans pay hospitals significantly more than Medicare does for the same services.

In some cases, this discrepancy has caused friction between hospital groups and payers. For example, the data in Indiana showed that in 2020, plans there paid the fourth-highest hospital prices (329% of Medicare rates) but had the fourth-lowest prices for physician services (126% of Medicare rates). Higher hospital prices were directly correlated with higher profits. Consequently, several insurers successfully renegotiated their hospital contracts, and advocacy groups called on the Indiana Legislature to implement price ceilings for hospital services. By contrast, data in Texas also revealed high prices related to Medicare rates, but further investigation showed that spiking labor costs were the primary contributor to the increase in prices, and that profit margins were lower than in previous years despite higher prices.

Plan sponsors will need to monitor the compliance obligations for their plans to ensure their plan participants have access to the information required by the regulations. In addition, sponsors should work with their consultants to use the public data available as a result of these regulations to identify opportunities to lower healthcare costs when possible, either through plan design structures (e.g., reference-based pricing) or vendor negotiations.

If you have questions about the price transparency requirements imposed by HPT or TiC or the potential compliance and enforcement impacts of these regulations, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

Centers for Medicare & Medicaid Services / Health Plan Transparency, available here.

The IRS Is Coming

The Inflation Reduction Act, which became law earlier this year, includes an additional $80 billion in funding for the Internal Revenue Service (the "IRS") over the next 10 years. More than half of that funding amount is targeted for tax enforcement and hiring new agents and auditors. Working with qualified tax counsel is therefore more important now than ever.

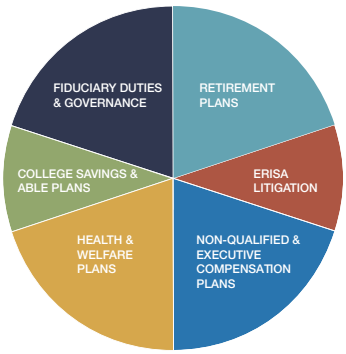
The IRS Commissioner has been directed to use this additional funding to conduct enforcement actions focused on high-end noncompliance. In its 2021 funding plan, the Treasury Department proposed hiring up to 87,000 new full-time employees, which means that high-net-worth individuals, corporations, and complex pass-through entities will likely see increased IRS audit activity. IRS compliance examinations of qualified plans and nonqualified deferred compensation plans are also likely to increase, continuing the upward trend in recent years.

One way to avoid an audit is to review plan documents and operational procedures and self-correct any identified errors before being contacted by the IRS. The penalties imposed for errors found during an IRS audit are many times higher than those imposed in the self-correction process. However, even if an employer receives an audit notice, a full scope examination may be avoided through the IRS's pilot audit program. First announced in June 2022, the program gives plan sponsors a 90-day window to review their plan's document and operations and correct any errors found through the Voluntary Correction Program within the IRS's Employee Plans Compliance Resolution System. Further details about the pilot audit program can be found in the IRS announcement or in Kutak Rock's associated client alert (available here).

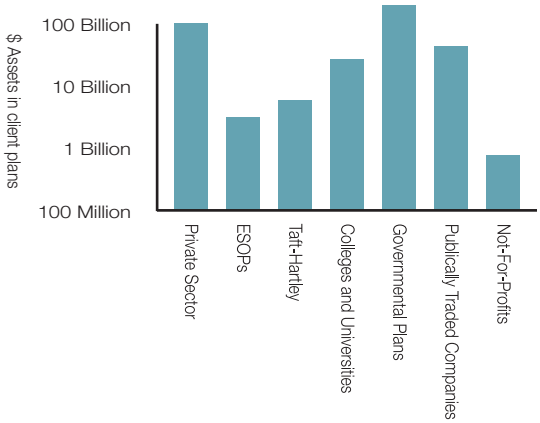
If you have questions about IRS audits or compliance examinations, have received an audit letter, or need assistance identifying or correcting any plan errors, please reach out to a member of the Kutak Rock Employee Benefits and Executive Compensation practice group.

About Us

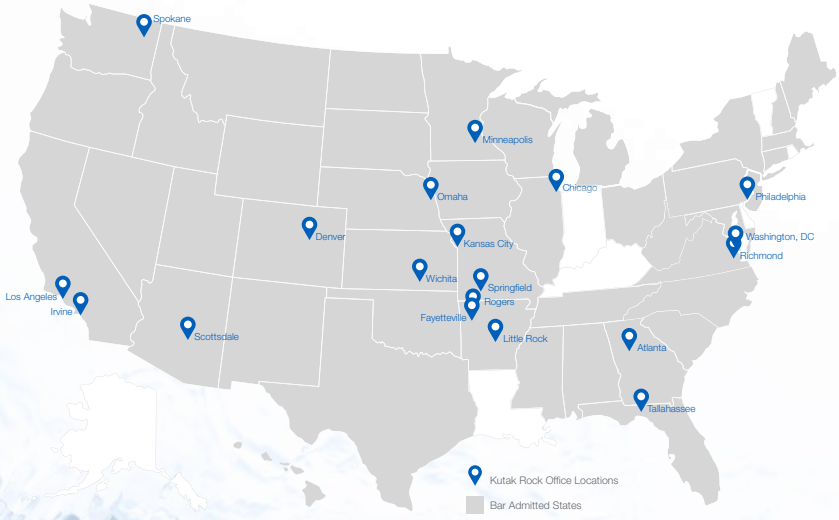
Who We Represent



What We Do



Where We Are



In Case You Missed It

- Group Health Plan Coverage for Abortions After Dobbs
- Deadline for Transparency in Coverage Compliance Fast Approaching
- IRS Announces Pre-Examination Compliance Pilot Program for Qualified Retirement Plan Sponsors
- Settlement Reached in Case Alleging Wellness Program Coercion
- More Guidance on Coverage of Over-the-Counter COVID-19 Tests
- The Supreme Court Rules for Participants in Hughes v. Northwestern
- New Guidance on Coverage of Over-the-Counter COVID-19 Tests
- Department of Labor Releases ERISA Plan Enforcement Statistics for 2021
- Department of Labor Begins Enforcing New Fee Disclosure Rules
- DOL Embraces ESG Investing in New Rule

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