KUTAKROCK

ISSUES

EMPLOYEE | BENEFITS

November 2019

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What's Inside

No Good Deed Goes Unpunished

How can there be anything wrong with a company offering financial planning services to its employees as an employee benefit? Or offering student loan repayment services? Certainly there can't be anything wrong with an employer providing employees with budgeting, personal debt management, or other financial wellness programs? The answer to these questions is that all of these wonderful new employee benefits being discussed in the marketplace and *The Wall Street Journal* can create big problems for employers depending on who is paying for the services and how they are being offered. If the employer and the employees are paying for 100% of the fair market value

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Actuarial Equivalence Litigation Presents New Challenge For Defined Benefit Plan Sponsors

In late 2018, class action counsel began filing lawsuits against large defined benefit plan sponsors alleging a novel cause of action—that the plans were using unreasonable actuarial assumptions to convert participant benefits to alternate forms of payment. Since then, the litigation has expanded to affect plans sponsored by American Airlines, Anheuser-Busch, AT&T, Corteva, Dow, Dupont, MetLife, PepsiCo, Raytheon, and U.S. Bancorp.

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New Excise Taxes on Excess Compensation Paid by Tax-Exempt Entities

The Tax Cuts and Jobs Act of 2017 created Section 4960 of the Internal Revenue Code ("Section 4960"), which imposes a 21% excise tax on excess compensation paid by an applicable tax-exempt organization to its five highest-paid employees ("covered employees"). Pending the issuance of proposed regulations, the IRS issued interim guidance, Notice 2019-09 (the "Notice"), to assist taxpayers in applying Section 4960. The Notice provides

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of these services, there shouldn't be too many issues. But if the employer (or more likely a service provider) is leveraging the company's retirement plan to offer these benefits, there could be big problems for the employer and the fiduciaries of the employer's retirement plan. And by "big" we mean financial damages, civil penalties, attorneys' fees, reputational harm and personal liability.

Over the last 10 years, the cost to administer retirement plans has decreased substantially, down over 50% according to the consulting firm NEPC, Inc. This is due to a number of factors—technology, competition, consolidation, Department of Labor mandated fee transparency, more sophisticated consumers and, of course, ERISA class action litigation. Employers have paid over $6 billion in ERISA settlements over the last decade. Most of this litigation relates to employers' failure to prudently monitor the administration and investment costs charged to their retirement plans. As a result of all of these factors, retirement plan service providers have been forced to reduce the fees they charge. In addition to all of this fee pressure on service providers, as the baby boomer generation continues to retire, the Institutional Retirement Income Council reports that over $1 billion leaves employer-sponsored retirement plans every day for IRA custodial accounts and annuities. That is a lot of lost revenue for retirement plan service providers.

Recently we have seen retirement plan administrators, consultants, TPAs and recordkeepers try to recoup this lost revenue in new and creative ways. Some recordkeepers, most notably Fidelity Investments, have started charging "infrastructure fees" to various mutual fund families if those mutual funds want to be available on the recordkeeper's investment platform. Earlier this year, *The Wall Street Journal* reported on the Department of Labor's investigation of Fidelity's infrastructure fees and the lack of disclosure of such fees to investors. According to Fidelity's own internal documents, the infrastructure fees were a means to recoup lost recordkeeping revenue and fix a "broken" revenue model suffering from "unsustainable economics." Empower, another leading recordkeeper, also requires mutual fund families to pay for access to small and mid-sized retirement plans.

Perhaps more troubling is a trend of recordkeepers offering proprietary products, ancillary services or access to ancillary services. These products include target date funds, managed accounts and stable value funds. Some recordkeepers will even pay their employees, advisers and representatives incentive compensation encouraging the sale of these products. In addition, many administrators are promoting "wellness" services through personal advice and web-based apps. These services go beyond financial education related to the company's retirement plan and include student loan and other debt consolidation services, and access to budgeting software and other financial service apps. Other administrators are re-evaluating the transaction fees they charge participants. These include fees for distributions, loans, QDROs, and even paper statements.

In addition to leveraging the employer's retirement plan to sell these ancillary services, some administrators appear to be mining participant data to market and sell other products and services. In April of this year, Vanderbilt University announced a $14.5 million settlement that would bar any plan recordkeeper from using information about its plan participants to market or sell products unrelated to the plan. The plaintiffs alleged that Vanderbilt, as a fiduciary to its retirement plan, failed to protect confidential participant data from being used by the plan's administrator in ways that did not directly relate to the administration of the plan. Other universities and plan sponsors are dealing with similar lawsuits.

ERISA fiduciaries must protect their participants' assets. As we have learned over the social media boom of the last 20 years, one "asset" that we each own is the data regarding our behavior and interests. ERISA fiduciaries must not only watch over and preserve the financial assets in an employee's 401(k) account, but they must also protect their employees' non-financial assets that are potentially being harvested by administrators and other service providers to the plan. ERISA's prudence requirement mandates that ERISA's fiduciaries safeguard all of their participants' assets, not just the dollars in their account. Even though an employer may legitimately see the value in offering financial wellness and other services to their employees, doing so by granting third parties access to mine and monetize retirement plan data could very well be the next good deed that gets the employer and the plans' fiduciaries punished.

Stock Options and Non-Recourse Loans

Generally, a stock option is treated as exercised at the time the grantee, usually an employee of the grantor/employer, pays the strike price and takes possession of the stock, whether actually or constructively. Sometimes when an employee cannot afford to pay the strike price, the employer will assist the employee by granting him or her a loan to cover the cost. Normally, this is not a problem, but when the loan is a "non-recourse loan" it can have unintended tax consequences.

Under a non-recourse loan, the employer's only collateral is the underlying shares subject to the stock option. This means that if the employee defaults on the loan, the employer can only take back the shares but cannot go after the employee for anything beyond the shares. This is significant because it means if the stock value drops below the loan value, the employee would presumably purposely default on the loan since there would be no incentive to pay off a loan only to receive shares of a lesser value and the employer would be entitled only to the stock.

The employee is, in essence, in a position no different than before he or she was granted the loan. The loan essentially becomes the strike price and the employee can walk away if it's not worth it to pay off the loan. Because of this, for tax reasons, the non-recourse loan promissory note is treated as a ***new*** option grant which is treated as "exercised" when paid.

This has very important tax consequences. For stock options that are incentive stock options, or "ISOs," under Internal Revenue Code Section 422, the holding period to qualify for long-term capital gains doesn't start when the options are purchased with the non-recourse loan, but, rather, when the loan is paid. For non-qualified stock options—i.e., stock options that don't qualify as ISOs—in addition to capital gains issues, the grantee doesn't experience a taxable event when the options are purchased with the non-recourse loan, but, rather, when the loan is paid. There may also be negative consequences under Code Section 409A, which puts restrictions, and potential penalties, on options granted with a strike price below fair market value.

It can also be tricky to determine at what point the non-recourse loan is considered paid for purposes of determining whether the new "options" have been exercised. Payment is determined based on the specific facts and circumstances. An employer who has or plans to assist employees in exercising stock options by granting them non-recourse loans should consult an attorney or tax professional to help make that determination.

States Adopt "Individual Mandates" and Employer Reporting Obligations

Multiple states and jurisdictions have enacted requirements for individuals to maintain minimum essential coverage, such as coverage under an employer-sponsored group health plan, along with related employer reporting obligations. These reporting obligations are in addition to those required by the Patient Protection and Affordable Care Act ("ACA"). Employers operating in these jurisdictions should ensure they are prepared to report offers of coverage for federal and state purposes.

California, Massachusetts, New Jersey, Rhode Island, Vermont, and Washington, D.C. (the "States") have adopted requirements that individuals maintain minimum essential coverage. In most of these jurisdictions, a penalty may apply if an individual fails to maintain minimum essential coverage. Massachusetts' requirements became effective in 2007. The requirements for New Jersey and Washington, D.C., became effective January 1, 2019. The California, Rhode Island, and Vermont requirements become effective January 1, 2020.

Each State maintains specific deadlines for furnishing the forms to individuals and filing them with the State. Penalties may apply if an employer fails to file/furnish the required forms.

To help enforce the minimum essential coverage requirements, employers are generally required to report offers of coverage to the State and to individuals. In general, each State except Vermont and Massachusetts use the ACA forms (e.g., Forms 1094-C and 1095-C) to report offers of coverage. Massachusetts uses Form MA 1099-HC, while individuals in Vermont report coverage on their individual state income tax returns. Each Sate maintains specific deadlines for furnishing the forms to individuals and filing them with the State. Penalties may apply if an employer fails to file/furnish the required forms.

Employers operating in Massachusetts, New Jersey, or Washington, D.C. should ensure they have processes and procedures in place to file and furnish the correct forms by the applicable deadlines. Employers may need to amend their contracts with the vendor that provides ACA reporting services to add State-level reporting services. When reporting offers of coverage to a specific State, employers should ensure they only report information for individuals who are subject to that State's reporting requirement. Employers should begin preparing for reporting 2020 offers of coverage for California and Rhode Island, in addition to Massachusetts, New Jersey, and Washington, D.C. If you need any assistance with reporting offers of coverage under the ACA or State requirements or working with your current vendor to add State-level reporting services, please contact a member of the Kutak Rock Employee Benefits Practice Group.

IRS Expands Availability Of Self-Correction Program

Earlier this year, the IRS issued a revised version of the Employee Plans Compliance Resolution System ("EPCRS") in Rev. Proc. 2019-19. Most significantly, the revised EPCRS gives plan sponsors the opportunity to self-correct certain types of errors that were not previously eligible for self-correction.

Expansion of Self-Correction through Retroactive Amendment

Previously, EPCRS permitted self-correction through a retroactive amendment only in a few instances. These included adopting retroactive amendments in certain cases when:

- The plan offered hardship distributions or loans when the plan document did not permit them.
- The plan had certain operational failures related to annual compensation limits.
- The plan allowed certain individuals to participate who were not eligible under the terms of the plan document.

The revised EPCRS now allows self-correction through a retroactive amendment in two additional circumstances:

- The plan may correct any operational error through a retroactive plan amendment if the plan amendment would result in an increase of a benefit, right or feature, applies to all employees eligible to participate in the plan, and is permitted under the Code and satisfies the correction principles set forth in EPCRS.
- The plan sponsor may retroactively amend the plan to increase the number of plan loans allowed at any one time.

Expansion of Self-Correction Opportunities for Plan Loan Errors

Under the prior versions of EPCRS, all plan loans had to be resolved through VCP or the Audit CAP program. The revised EPCRS permits loan errors to be self-corrected, with two important restrictions:

- Loan errors cannot be self-corrected if the terms of the loan did not comply with the limitations of the Code.
- Because the Department of Labor does not accept self-correction as an acceptable mode of correction, a complete correction with the Department of Labor may still require a VCP filing or correction via Audit CAP.

Ultimately, although the revised EPCRS provides plan sponsors with some significant opportunities to self-correct new types of errors, we recommend consulting with counsel on any self-correction to ensure that it complies with the terms of the revised EPCRS procedure.

Wilson v. Safelite Group, Inc.—ERISA Implications for Top Hat Plans

A recent 6th Circuit case—*Wilson v. Safelite Group, Inc.* (July 10, 2019)—illustrates why plan sponsors should take steps to ensure their nonqualified deferred compensation plans comply with ERISA's "top-hat" plan exception. A non-top-hat employee benefit plan must comply with ERISA's funding requirements, nondiscrimination in coverage and benefits, vesting and fiduciary rules. Where a plan satisfies the "top-hat" plan exception, as did the plan at issue in *Wilson*, the ERISA implications are limited and can serve as an additional layer of protection for the plan sponsor, including by preempting state law claims.

A top-hat plan is a deferred compensation plan that limits participation to a select group of management or highly compensated employees. A top-hat plan is still subject to reporting requirements, but the plan sponsor may satisfy these requirements simply by filing a one-time letter with the Department of Labor. A top-hat plan is also subject to ERISA's claims procedures requirements, which require an internal review and appeals procedure before a participant may take the claim to litigation. Further, discovery generally is limited to the administrative record developed during the review.

In *Wilson*, Safelite's CEO participated in the company's top-hat nonqualified deferred compensation plan, which permitted eligible executive employees to defer their base annual salary, long-term bonuses, and transaction incentive bonuses. Following Mr. Wilson's termination of employment, his $9.1 million plan account incurred substantial penalties due to deferral election failures under Section 409A of the Internal

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Revenue Code ("Section 409A") that were identified by the IRS in a 2014 federal audit. Such penalties included immediate income inclusion, a 20% excise tax, and premium interest. Mr. Wilson sued Safelite in federal court, asserting under state law that (1) Safelite's failure to comply with Section 409A constituted a breach of contract, and (2) Safelite negligently misrepresented to him that his deferral elections were appropriate. Safelite moved for summary judgment on Mr. Wilson's state law claims, arguing they were preempted by ERISA.

The district court found the plan to be an "employee pension benefit plan" covered under ERISA, which preempts the state law claims. As the plan was a top-hat plan subject to ERISA, Mr. Wilson's only option was to pursue claims under the plan's ERISA-compliant claims procedures. Mr. Wilson was granted 28 days to file an amended complaint asserting claims under ERISA's civil enforcement provisions, but he failed to do so. Safelite was granted relief by summary judgment (as affirmed by the 6th Circuit).

In light of the decision in *Wilson*, we recommend sponsors of non-qualified deferred compensation plans confirm their plans constitute ERISA top-hat plans. Specifically, plan sponsors should confirm each applicable plan (1) contains language limiting participation to a select group of management or highly compensated employees, (2) has the appropriate ERISA claims procedures, (3) includes provisions disclaiming responsibility for Section 409A violations, and (4) has been included in a top-hat letter filed with the Department of Labor.

Specifically, plan sponsors should confirm each applicable plan

1. *Contains language limiting participation to a select group of management or highly compensated employees*
2. *Has the appropriate ERISA claims procedures*
3. *Includes provisions disclaiming responsibility for Section 409A violations*
4. *Has been included in a top-hat letter filed with the Department of Labor.*

The cases generally allege that plan sponsors are failing to fulfill their duties under their plans by failing to provide actuarially equivalent benefits to participants. To date, the complaints have taken one of two forms:

- Plan sponsors are using unreasonable early retirement factors, which result in inappropriate reductions of benefits for early retirees.
- The plans in question are generally failing to provide actuarially equivalent benefits because the interest rates and mortality tables used to calculate participant benefits are inappropriate. Although the complaints acknowledge that interest rates and mortality tables must be considered together in determining whether the actuarial factors utilized by the plan are reasonable, they generally focus on mortality tables that do not reflect improvements in mortality. The complaints emphasize that, in many cases, plan sponsors did not update the mortality tables since the inception of the plan. It is not

Co-Pay Accumulator Programs Await Further Guidance

In April 2019 the U.S. Department of Health and Human Services ("HHS") issued regulations addressing whether the amount of financial support provided by drug manufacturers, such as co-pay assistance coupons, must be counted toward the annual cost-sharing limits under the Patient Protection and Affordable Care Act (the "ACA"). HHS was concerned that drug manufacturers' cost-sharing support increased the cost of prescription drugs and encouraged patients to use higher-cost brand name drugs instead of less expensive generic drugs. Accordingly, under the new regulation, amounts individuals pay toward cost-sharing using support provided by a drug manufacturer (e.g., a co-pay coupon) to reduce or eliminate their out-of-pocket costs for certain brand-name prescription drugs are generally not required to be counted toward the annual cost-sharing limits under the ACA. To qualify for this treatment, a brand-name prescription drug must have a generic equivalent that is available and medically appropriate. Under this

uncommon for defined benefit plans to update mortality tables infrequently, and very little guidance exists regarding what mortality tables a defined benefit plan can permissibly use.

To date, the decisions issued by courts suggest that there is some possibility that plaintiffs can succeed in claiming that a plan is obligated to use reasonable mortality tables. In *Smith v. U.S. Bancorp*, a case challenging the early retirement factors in U.S. Bancorp's defined benefit plan, the District Court for the District of Minnesota rejected U.S. Bancorp's motion to dismiss, relying on the general principle that distributions from a plan must be actuarially equivalent to the plan's accrued benefit at normal retirement age and that unreasonable actuarial equivalence factors can cause those benefits not to be actuarially equivalent.

In contrast, in *DuBuske v. PepsiCo*., the District Court for the Southern District of New York dismissed similar claims regarding the early retirement factors utilized under PepsiCo's defined benefit plan. There, the Court determined that the case fundamentally arose under ERISA's anti-forfeiture provision, which only applied after the attainment of normal retirement age. This arguably leaves open the possibility of claims being made by participants based on inappropriate actuarial factors that apply to participants who have attained normal retirement age.

Although a clear precedent has not yet emerged from these lawsuits, we recommend that defined benefit plan sponsors consult with their actuaries to determine whether the actuarial assumptions utilized by their plans are in line with those of comparable plans. We also recommend that plan sponsors continue to monitor developments in these lawsuits as they arise.

regulation, a group health plan could be amended to exclude certain co-pay assistance from counting toward a participant's annual cost-sharing limit, which would result in a participant spending her own funds (instead of only the co-pay coupon) to reach the annual cost-sharing limit.

In August 2019 the Departments of Labor, HHS, and Treasury (the "Departments") released new FAQ guidance regarding the circumstances under which manufacturers' drug co-pay assistance may be excluded from the ACA's annual cost-sharing limit. The FAQ explained that for plan years beginning on or after January 1, 2020, plans are permitted (but not required) to exclude the value of drug manufacturers' coupons from counting toward the ACA's cost-sharing limit when a medically appropriate generic equivalent drug is available. The Departments recognized that "this provision can be read to imply that, in any other circumstances, group health plans … are required to count such coupon amounts toward the annual limitation on cost sharing." The Departments also recognized that this requirement could also conflict with certain rules that apply to high-deductible health plans.

In the FAQ, the Departments announced they would undertake new rulemaking and that until new rules are issued and effective, "the Departments will not initiate an enforcement action if…a group health plan excludes the value of drug manufacturers' coupons from the annual limitation on cost sharing, including in circumstances in which there is no medically appropriate generic equivalent available." This FAQ generally allows a group health plan to be amended to exclude the value of drug manufacturers' coupons from the ACA's annual cost-sharing limit even if the drug for which the coupon is provided does not have a medically appropriate generic equivalent available.

Employers that have adopted the co-pay accumulator program should ensure they comply with the HHS regulations and FAQ guidance

Employers that have adopted the co-pay accumulator program should ensure they comply with the HHS regulations and FAQ guidance, as well as applicable state laws that regulate the use of prescription drug coupons and similar financial support. Those employers should also ensure the plan document and summary plan description include specific provisions relating to the co-pay accumulator program, clearly explain how the program works, and identify the drugs and manufacturer assistance to which it applies. Employers should continue to monitor regulatory developments, as the Departments are likely to issue new co-pay accumulator program regulations in 2020. If you need any assistance with co-pay accumulator programs, please contact a member of the Kutak Rock Employee Benefits Practice Group.

Walgreens' Target Date Fund Complaint Illustrates Need For Prudent Target Date Review Process

This August, participants in Walgreens' 401(k) plan, a $10 billion plan with approximately 130,000 participants, filed a class action lawsuit focusing on the Northern Trust Focus Target Retirement Trusts, the plan's target date fund series. The funds comprise approximately 30% of the plan's assets, and the participants are seeking more than $300 million in damages. The complaint provides an important illustration of the need to have a well-documented target date fund review process.

The participants bringing the lawsuit point to a number of factors that they suggest point to an inadequate selection and review process by the Walgreens plan fiduciaries. In particular, the plaintiffs allege that:

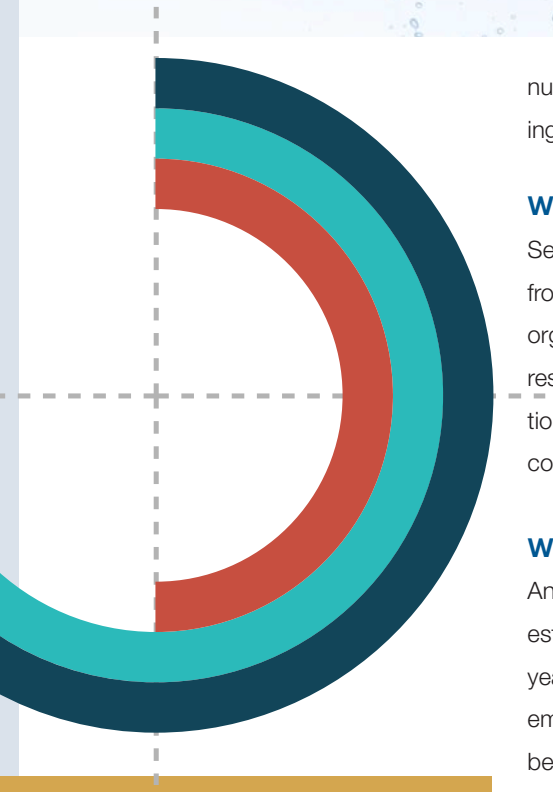
- The funds were first offered in 2010. Since their inception, they have generally performed in the bottom tenth to thirtieth percentile of target date funds.
- The selection of the funds by the Walgreens plan fiduciaries in 2013, given their performance, allegedly shows that the plan fiduciaries did not prudently compare the funds to other available options and to their benchmarks.
- The plan fiduciaries have continued to utilize the funds and add new funds in the series as they became available despite the ongoing performance issues of the funds, allegedly illustrating the failure of the plan fiduciaries to monitor the funds.

Although this case is still in the initial complaint stage, the complaint demonstrates the need for plan fiduciaries to document their target date review process. The complaint, in particular, focuses on the performance of the funds. However, in addition to reviewing the performance and fees of target date funds annually, plan fiduciaries should also review:

- The glide path of the target date funds and how it compares to peers;
- The asset allocation and underlying holdings of the funds;
- The continued appropriateness of the funds taking into account participant demographics and the availability of other plans; and
- The investment strategy of the funds.

Given that target date funds are typically the largest investment in most defined contribution plans, we anticipate that the plaintiffs' bar will continue to seek out opportunities to sue plan fiduciaries based on alleged deficiencies in their target date selection and review process. As a result, we recommend that plan fiduciaries ensure they conduct a detailed review of their target date funds annually.

Although this case is still in the initial complaint stage, the complaint demonstrates the need for plan fiduciaries to document their target date review process.



numerous Q&As that address issues surrounding the application of Section 4960.

Which Employers Are Affected?

Section 4960 applies to organizations exempt from taxation under Section 501(a) and "related organizations." Related organizations with respect to an applicable tax-exempt organization ("ATEO") include entities that control or are controlled by the ATEO.

Who Are Covered Employees?

An ATEO's covered employees are its five highest-compensated employees for the taxable year plus any employees who were covered employees for any of the ATEO's prior tax years beginning after December 31, 2016. Accordingly, an individual who is a covered employee at any point beginning in 2017 or later will always retain that status, even after retirement. The determination of the highest-compensated employees is based on the employee's compensation for services performed for both the ATEO and related organizations.

What Payments are Subject to the Excise Tax?

The 21% excise tax applies to (a) remuneration over $1 million paid during the taxable year to a covered employee, and (b) any excess parachute payments paid to a covered employee. "Remuneration" includes wages paid to the employee and nonqualified deferred compensation included in the employee's gross income under Section 457(f). An "excess parachute payment" means the portion of a payment to a covered employee contingent on separation from employment, which exceeds three times the employee's average annual compensation for the ATEO or a related organization for the five years preceding such separation.

Who is Taxed?

The excise tax is imposed on the common-law employer of the covered employee. Generally, when a covered employee has more than one common-law employer, and each such employer is an ATEO or related organization, each employer is liable for the share of the Section 4960 excise tax allocable to the remuneration paid by such employer.

What Should Tax-Exempt Entities Do Next?

ATEOs should review their existing compensation arrangements for highly compensated employees to identify opportunities that may avoid or minimize the Section 4960 excise tax. For example, the vesting of deferred compensation could be staggered over several years (as opposed to cliff vesting) to avoid the excess remuneration tax. Similarly, severance payments could be reduced to avoid the parachute payment tax.

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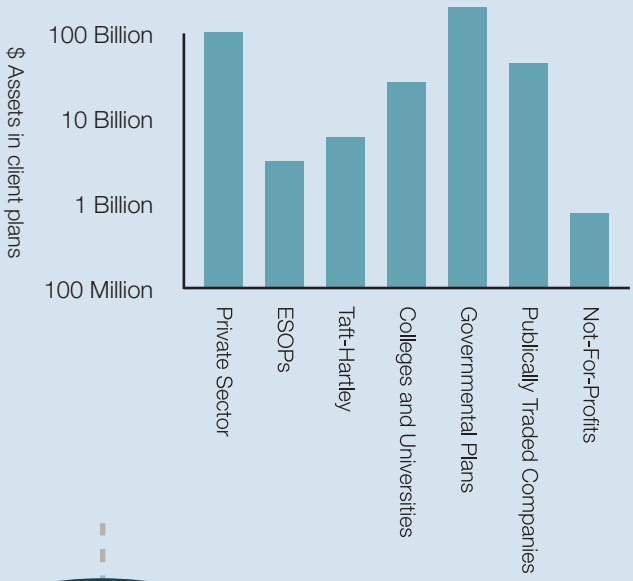

In Case You Missed it

- 2020 COLA Figures Chart
- December 6 | Extension of ACA Reporting Deadlines and Additional Relief
- November 14 | Cost-of-Living Adjustments (COLA) Released for 2020
- October 22 | New ERISA Electronic Delivery Proposal Announced
- October 11 | California Employers Subject to New FSA Notice Requirements
- July 25 | IRS Guidance Expands Preventive Care Under High Deductible Health Plans
- May 31 | New Jersey Becomes First State to Require Pre-Tax Transportation Benefits
- December 27 | Incorrectly Deferring the Last Payroll Period In Your Nonqualified Plan Could Lead to Penalties
- December 19 | $160,000 Tobacco Surcharge? Yes, if your Wellness Program is Noncompliant
- November 26 | 2019 Cost-of-Living Adjustment and Year-End Reminders
- November 13 | Record Keepers Respond to Hardship Withdrawal Changes
- December 20 | SECURE Act Makes Sweeping Changes to Retirement Plans

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