ISSUES
EMPLOYEE BENEFITS

KUTAKROCK

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Your resource for legal alerts, current trends and legislative analysis.

What's Inside

IRS Approves Game-Changing Approach to Employee Benefits

Earlier this year, the Internal Revenue Service ("IRS") issued Private Letter Ruling 202434006 (the "PLR") approving an arrangement under which an employer permits its employees to allocate employer contributions to the benefit account of the employee's choosing. If the IRS chooses to expand the guidance in this PLR to other employers, this could dramatically change an employer's approach to providing benefits to employees.

As described in the PLR, employees were given the choice of allocating their employer contribution among four different benefits:

1. a defined contribution retirement plan;
2. a retiree health reimbursement arrangement;
3. a health savings account; and
4. a qualified educational assistance program.

Employees could elect to allocate different percentages of employer contribution among the different benefits. The election would be made annually before the start of each year and is irrevocable when made. The IRS clarified that the employer contribution could *not* be paid in cash or another taxable benefit.

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Emerging Litigation on Use of Forfeited Retirement Contributions: What is in the Best Interests of Plan Participants?

Vesting periods for defined contribution plans incentivize employee retention and ensure that employers' money is invested in loyal employees. When employees terminate employment early, forfeitures resulting from non-vested contributions grant employers the opportunity to reinvest these funds back into retirement plans. Recently, employers' common practice of using forfeitures to reduce their future employer contributions to the plan has faced scrutiny and become the subject of numerous lawsuits. This litigation, while previously dismissed at earlier stages in litigation, is now making its way through the cracks.

What Are Forfeitures and How Are They Used?

Employer-sponsored defined contribution plans, such as 401(k) and 403(b) plans, are retirement plans funded by contributions from both the employee and the employer. An employee may contribute a portion of their paycheck to the plan, up to the employee contribution limit set by the Internal Revenue Service ("IRS"). Many employers then match a certain percentage of these employee contributions or make a separate discretionary contribution on behalf of all employees. Employer contributions are

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A PLR applies only to the employer to whom it is issued, but the PLR can serve as a guide to other employers considering the use of a similar benefit arrangement or structure. This PLR demonstrates that the IRS is open to different structures that allow participants to allocate their employer contributions among various employee benefits—potentially even benefits that are not addressed in the PLR. Since PLRs are often very fact-dependent, the safest approach is for an employer considering a benefit arrangement that differs from the facts in the PLR to obtain its own favorable PLR from the IRS.

If you are interested in adding similar flexibility to your employee benefits lineup, or if you have questions regarding potential benefits structures like those in the PLR, please reach out to a member of our Employee Benefits and Executive Compensation group.

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typically subject to a vesting period, which specifies the duration that must pass before the employee has a right to 100% of the employer's contributions. If an employee leaves the company before contributions have fully vested, any non-vested contributions made by the employer are relinquished by the employee and deemed a "forfeiture."

Plan sponsors must use forfeitures pursuant to the rules set forth in their plan documents and in compliance with IRS and ERISA guidelines. Plan sponsors often take advantage of one of three common forfeiture uses: (1) to offset reasonable plan expenses; (2) to offset future employer contributions; and (3) to reallocate to current employee participants. In 2023, the IRS issued a proposed regulation permitting all three of these forfeiture uses in an attempt to make these long-standing practices legally permissible under regulation.

Emerging Litigation on the Matter

For decades, plan sponsors have utilized forfeitures to offset future employer contributions. Despite an acceptable and widely followed practice, recent litigation has alleged that this use of forfeitures fails to comply with fiduciary requirements under ERISA. Lawsuits are surfacing against plan sponsors who elected to offset future contributions rather than minimize the administrative expenses of current participants or allocate the forfeitures as an additional contribution, claiming these plan sponsors are acting as fiduciaries of the plan and are liable under ERISA for breaching their fiduciary duties of loyalty. The duty of loyalty requires a fiduciary to act solely in the best interests of participants and beneficiaries when providing benefits and defraying reasonable administrative expenses. Participants in pending lawsuits have argued that in choosing to use forfeitures to reduce employer contributions rather than using them to reduce the plan's administrative expenses or allocate them as an additional contribution, the fiduciaries have acted in the best interests of the employer and not the participant, thereby breaching their fiduciary duties under ERISA.

Multiple class action lawsuits have been filed against plan sponsors regarding their practice of allocating forfeitures. Expectations that these cases would not survive the motion to dismiss stage are quickly adjusting in light of a May 2024 decision in the Southern District of California. In *Perez-Cruet v. Qualcomm, Inc.*, the plaintiff, a current participant in Qualcomm's defined contribution plan, alleged that as managers of the plan, the defendants violated ERISA when choosing to use forfeited plan contributions to offset future Qualcomm contributions rather than defray the administrative expenses of the plan for current plan participants. The plaintiff claimed breach of fiduciary duty of loyalty, breach of fiduciary duty of prudence, breach of ERISA's anti-inurement rule, use of forfeitures as a prohibited transaction, and failure to monitor fiduciaries. The court found each of the plaintiff's claims plausible at the pleading stage, denying the motion to dismiss on all claims, and pushing the lawsuit into the next stage of litigation. Less than one month later, a case nearly identical to *Qualcomm* was also heard at the motion to dismiss stage. In *Hutchins v. HP Inc.*, the U.S. District Court for the Southern District of California granted all motions to dismiss. These conflicting verdicts demonstrate how uncertain the legal landscape is surrounding forfeiture allocation.

What Can You Do To Avoid Litigation?

Plan sponsors and fiduciaries should review their plans' terms to ensure that their plans are currently being administered in accordance with their terms. If a plan establishes that forfeiture utilization is based on plan discretion, the company should ensure that these decisions are being prudently documented. Employers should also consider adjusting a plan's administration of forfeiture use to eliminate any risks of fiduciary breach under ERISA.

Employers and plan sponsors should consider amending their plans to definitively state how forfeitures are to be utilized and eliminate any discretionary authority that may be subject to fiduciary duties under ERISA. However, the lack of flexibility to use forfeitures as needed based on circumstances may be confining and undesirable for some employers. An alternative approach is to amend the plan or otherwise clearly articulate that the employer is making the decision on how to use forfeitures as the "plan sponsor" and not as a "fiduciary" of the plan.

Our Employee Benefits and Executive Compensation group is available to assist with a review of your retirement plan documents and to address any questions about using forfeitures under your plan.

SECURE 2.0 Considerations for 2025

Several mandatory and optional elements of SECURE 2.0 become effective in 2025, including the following:

Ages 60–63 (or "Super") Catch-ups

This optional provision allows 401(k), 403(b), governmental 457(b), and SIMPLE plans that offer catch-up contributions to permit participants who attain ages 60–63 during the year to contribute up to 150% of the regular (age 50+) catch-up limit. Be aware of the following:

Most plan recordkeepers are assuming plan sponsors want to implement this provision and may send "opt-out" election notifications rather than an "opt-in" election. These notifications are often mass-emailed and could get caught in an enterprise's spam filter.

Implementation requires careful coordination and preparation by the plan sponsor and its payroll system and the plan's recordkeeper. Individuals who will turn at least 60 (but not 64) during the plan year must be identified so they can contribute up to the "super" catch-up limit. Participants who turn age 64 during the year may contribute only up to the age 50+ catch-up limit.

This provision does not change the 2026 requirement that catch-up contributions by participants whose prior year wages were more than $145,000 must be made on a Roth (post-tax) basis.

Auto-Portability

Recordkeepers and other third parties may begin offering plans a way to transfer force-out distributions (i.e., amounts of up to $5,000 (or $7,000 under SECURE 2.0)) from a prior employer's automatic IRA to the new employer's plan. This *optional* provision applies to 401(a) (other than defined benefit plans), 401(k), 403(b), and governmental 457(b) plans. Be aware of the following:

The U.S. Department of Labor (the "DOL") issued a proposed rule in January 2024 that provided some guidance on how service providers may implement this provision.

However, the DOL has not issued any guidance on what features and factors a plan sponsor/fiduciary must consider in selecting a portability provider. Some of the portability products we have encountered call into question the ability to comply with existing DOL and IRS fiduciary safe harbors/guidance for force-out distributions and accepting rollovers into the plan.

Implementing this provision is likely a fiduciary decision and fiduciaries would need to engage in a fact-intensive inquiry before implementing this optional feature.

Long-Term, Part-Time ("LTPT") Rules

This *mandatory* provision applies to 401(k) plans and ERISA 403(b) plans.

SECURE 1.0 required 401(k) plans to allow LTPT employees to make deferrals starting in 2024, after completing three consecutive years with 500 or more hours of service. SECURE 2.0 shortens the 2025 requirement to two years and extends the requirement to ERISA 403(b) plans. Employers are still not required to make matching or nonelective contributions to LTPT employees, but if LTPT employees are eligible for employer contributions, they earn vesting credit for years with 500 or more hours of service.

Starting in 2025, LTPT employees who worked at least 500 hours in two consecutive years between 2021 and 2024 must be allowed to make elective deferrals to 401(k) plans. The IRS recently confirmed that 403(b) plans must allow LTPT employees to defer, effective January 1, 2025, if they worked at least 500 hours in 2023 and 2024, even if they are not scheduled to and did not work 20 hours a week. However, exclusions of certain classifications, including students and nonresident aliens, are still permitted.

Amendments

The deadline to amend most plans for SECURE 1.0, the CARES Act, and SECURE 2.0 is December 31, 2026. Nongovernmental 457(b) plans must still be amended by December 31, 2025. Later deadlines apply to collectively bargained plans, governmental plans, and 403(b) plans sponsored by public schools. If you have questions about SECURE 2.0 compliance, please reach out to a member of our Employee Benefits and Executive Compensation group.

Secure 2.0 Highlights

Ages 60–63 (or "Super") Catch-ups
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To Non-Compete (or Not To Non-Compete)

On April 23, 2024, the Federal Trade Commission ("FTC") adopted a rule prohibiting employers from entering into non-competes with their employees. The FTC rule, originally set to take effect on September 4, 2024, was intended to allow employees to change jobs more easily without fear of prior employers limiting their future job prospects. However, on August 20, 2024, a federal court struck down the FTC rule and issued a nationwide injunction prohibiting its enforcement.[1]

Although the case is currently on appeal, the FTC rule is currently not enforceable. Nevertheless, employers should be aware that this decision could cause state or federal lawmakers to enact statutory limitations on non-competes. As a result, employers whose plans or compensation arrangements utilize non-competes may want to consider assessing the potential impact if their non-competes are rendered invalid. Below are some examples of employee benefit arrangements that commonly utilize non-competes.

Code Section 457(f) Plans

A tax-exempt entity may sponsor a nonqualified deferred compensation plan under Section 457(f) of the Internal Revenue Code of 1986, as amended (the "Code"), which allows a select group of highly compensated or key management employees to receive deferred compensation in excess of the contribution limits imposed on plans under Code Sections 401(k), 403(b), and 457(b). Under Code Section 457(f), the deferred amount is included in the employee's gross income once there is no substantial risk of forfeiture of the compensation, in other words, once the compensation vests. Tax-exempt entities may currently treat non-competes as creating a substantial risk of forfeiture. If a non-compete were deemed invalid, however, amounts deferred that are contingent on compliance with such non-compete may become taxable earlier than intended.

Restricted Stock

Under Code Section 83, transfers of property in connection with the performance of services, including restricted stock, are generally included in the employee's gross income once the property is not subject to a substantial risk of forfeiture (i.e., when it vests). Currently, compliance with a non-compete can create a substantial risk of forfeiture under Code Section 83. If a substantial risk of forfeiture lapses based on an unenforceable non-compete, however, the restricted stock would become immediately taxable under Code Section 83.

Golden Parachutes

Code Section 280G imposes a 20% excise tax on certain recipients of excess compensation (often referred to as "golden parachute payments") in connection with a change in control. The corporation paying the golden parachute also loses a tax deduction. Corporations may minimize the impact of Section 280G on golden parachute payments by attributing a value to non-competes as reasonable compensation. If non-competes become unenforceable, however, this commonly used mitigation strategy might become unavailable.

The future of non-competes is far from settled. If you would like assistance navigating this developing area and determining how it applies to your business, please reach out to a member of our Employee Benefits and Executive Compensation group.

1. *Ryan LLC v. FTC,* No. 3:2024-cv-00986, N.D. Tx.

New Employees

Will Jennings was a law clerk in the Omaha office this summer and is a 3L at the University of Nebraska College of Law. After graduating in 2025, he will join the Employee Benefits and Executive Compensation group as an associate. Will grew up in Lincoln, Nebraska and graduated from the University of Nebraska-Lincoln with a major in business administration. In his free time, Will enjoys reading, playing trivia, and watching sports.

Jason Kotlyarov is an associate in the Kansas City office and joined the firm in March 2024. Prior to joining Kutak Rock, Jason's practice focused on the representation of multiemployer (Taft-Hartley) employee benefit plans. Jason is a graduate of the University of Missouri-Kansas City, earning his B.S. in accounting, J.D. and LL.M. (Master of Laws) in taxation from the institution. In his free time, Jason enjoys cooking, rooting for the Kansas City Chiefs and Royals, and spending time with family and friends.

Managed Accounts and Investment Advice: What Fiduciaries Should Know

Recently, multiple lawsuits have been brought against large recordkeepers (e.g., TIAA, Empower, Fidelity) and other service providers that offer investment advice and managed account products to retirement plan participants. These lawsuits serve as a reminder that investment advice is fiduciary advice that plan fiduciaries must review and monitor regardless of how it is offered (in person, phone, computer program, website module).

An underlying theme in the recent litigation is self-dealing. The growing popularity of low-cost, passively managed investment options and pressure to reduce fees has reduced recordkeeper revenue. To offset this decrease in revenue, plaintiffs in the recent cases claim that self-dealing arises in several ways, one of which is that investment advice programs improperly direct participants to invest in a recordkeeper's proprietary investment products. Employees are allegedly incentivized through "bonus" quotas to push managed account products and proprietary products of the service providers. The investment advice and managed account services allegedly provide biased investment advice, directing participant investments into the recordkeeper's proprietary investments even if other investments might be more suitable.

Selecting an investment advice provider or managed account product is a fiduciary decision that requires a diligent initial review and ongoing monitoring thereafter. Fiduciaries should understand the following:

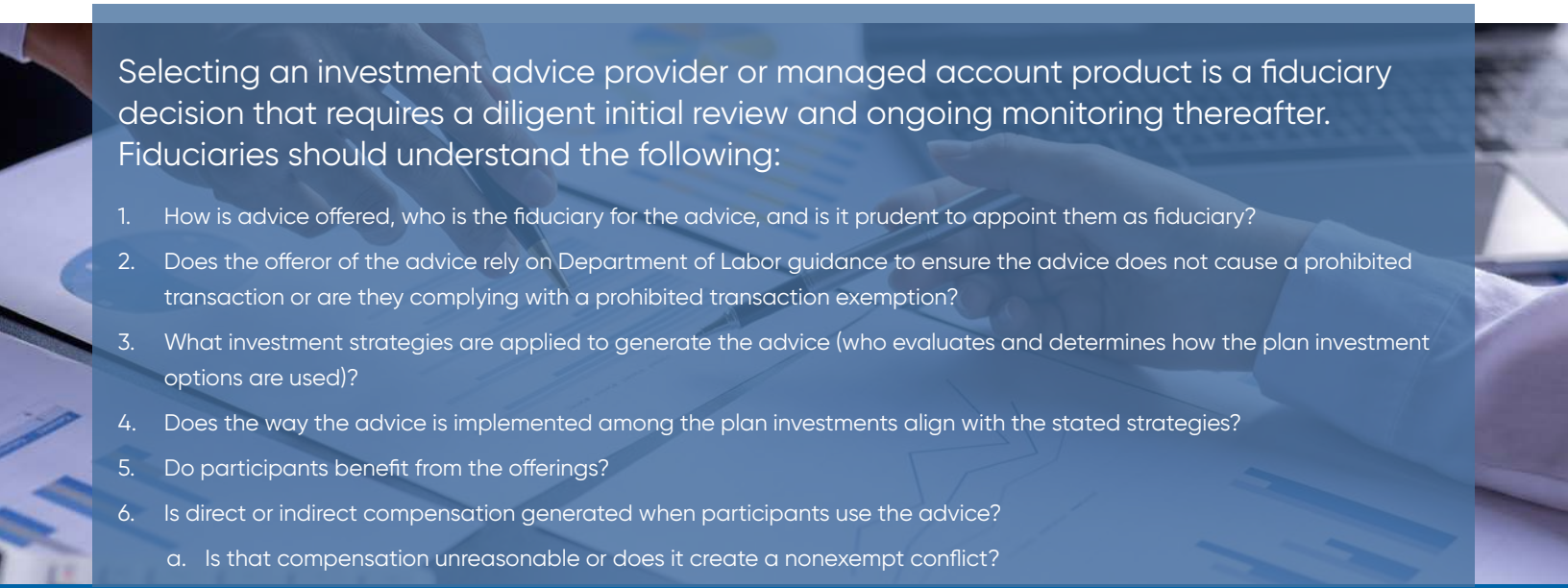
1. How is advice offered, who is the fiduciary for the advice, and is it prudent to appoint them as fiduciary?
2. Does the offeror of the advice rely on Department of Labor guidance to ensure the advice does not cause a prohibited transaction or are they complying with a prohibited transaction exemption?
3. What investment strategies are applied to generate the advice (who evaluates and determines how the plan investment options are used)?
4. Does the way the advice is implemented among the plan investments align with the stated strategies?
5. Do participants benefit from the offerings?
6. Is direct or indirect compensation generated when participants use the advice?
    a. Is that compensation unreasonable or does it create a nonexempt conflict?

The above list is not comprehensive, and fiduciaries need to be aware of these issues and more to ensure that the managed account program and investment advice services are offered in a manner that solely benefits participants and their beneficiaries (e.g., is the higher cost of the managed account service providing increased value?). If a plan sponsor chooses to offer a managed account product and cannot explain or demonstrate how the product's operation is in the best interests of participants, then the sponsor runs the risk of breaching its own fiduciary responsibilities.

What Should Fiduciaries Do Now?

Fiduciaries should review their investment advice offerings and continue to monitor the advice provided. We recommend having a formalized process to ensure that these issues are periodically reviewed and confirmed as appropriate.

If you have questions or need assistance reviewing your plan's participant investment advice or managed account product, please contact a member of our Employee Benefits and Executive Compensation group.



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The State of Cross-Plan Offsetting Litigation

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 ("TPA") 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 article examines recent court cases and developments that involve cross-plan offsetting. Fiduciaries need to be aware of cross-plan offsetting and how it impacts plan participants because the practice may violate ERISA.

Eighth Circuit's Decision in *Peterson*

In 2019, the United States Court of Appeals for the Eighth Circuit addressed cross-plan offsetting in *Peterson v. UnitedHealth Group* ("UHC"). The Eighth Circuit held that UHC could not engage in cross-plan offsetting without express approval in the plan document.

The Eighth Circuit did not decide whether cross-plan offsetting is legal, but it did state that the practice is "in tension with the requirements of ERISA." The clearest guidance for plan sponsors came from the district court's opinion, which held that a plan fiduciary is obligated to make a careful and fully informed decision about whether allowing a TPA to engage in cross-plan offsetting is in the best interests of the participants in their plan.

In response, UHC released an update on its cross-plan offsetting system in May 2023. UHC noted that the *Peterson* court found cross-plan offsetting to be unlawful only when it is not expressly authorized in the plan document. Consequently, UHC has inserted express authorization for cross-plan offsetting into its plan documents and automatically enrolls such plans into its offsetting system unless the plan affirmatively opts out of participating. Additionally, UHC has promised to assist plan sponsors with any litigation stemming from their plan's participation in UHC's cross-plan offsetting system since such participation comes with a risk that the provider claims that offsetting is an invalid payment method and elects to balance bill the Plan B participant instead.

The Department of Labor Consistently Asserts That Cross-Plan Offsetting Violates ERISA

During *Peterson*, the Department of Labor (the "DOL") submitted a brief to the Eighth Circuit expressing its view that cross-plan offsetting violates ERISA because the practice exposes the participants in Plan B to balance billing by out-of-network providers. The DOL has previously stated that "cross-plan offsetting practices punish and shortchange health plan participants and their beneficiaries and violate basic tenets of [ERISA]" and has backed up this position in other litigation. For example, in September 2023, the DOL reached a settlement with EmblemHealth Inc., a New York-based insurer and TPA, resolving claims that Emblem breached its fiduciary duties under ERISA by engaging in cross-plan offsetting.

Courts Continue To Not Reach the Merits

In July 2024, the Eighth Circuit dismissed *Smith v. UnitedHealth Grp.*, another case involving UHC's cross-plan offsetting system. In *Smith*, the plaintiffs alleged that their plan document's authorization of cross-plan offsetting was inconsistent with ERISA, thereby constituting a breach of fiduciary duty. The Eighth Circuit held that in order to reach the issue of whether cross-plan offsetting violates ERISA, the plaintiffs must first show that they were harmed by the practice. The denial of benefits that a plan participant is contractually entitled to receive under the plan would be a sufficient harm, but the Eighth Circuit determined that the plaintiffs had received all the benefits to which they were entitled. The plaintiffs also alleged that they had been harmed because of the potential exposure to balance billing. However, the Eighth Circuit rejected this claim as speculative, in part because the district court found no evidence that a provider ever balance billed a patient even though UHC had cancelled hundreds of millions of dollars in debts through cross-plan offsets. Because the plaintiffs failed to show they had suffered a concrete injury, the case was dismissed on standing grounds before reaching the merits.

In January 2024, a federal district court in New Jersey took the opposite approach in *Brainbuilders LLC v. Aetna Life Ins. Co*. and agreed with the DOL's view that the risk of balance billing itself is a sufficient harm to allow a court to reach the issue of cross-plan offsetting's legality. However, the New Jersey district court also dismissed the case on standing grounds before reaching the merits because the plan's anti-assignment clause barred the plaintiff medical provider from bringing a claim on behalf of the plan's participants.

Action Items for Plan Sponsors

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

(Cross-Plan Offsetting CONTINUED ON PAGE 7)

We're here to help. If you have questions or need advice, please contact a member of our Employee Benefits and Executive Compensation group.

(Cross-Plan Offsetting CONTINUED FROM PAGE 6)

- Review plan documents and summary plan descriptions to verify the plan authorizes cross-plan offsetting.
- Review administrative service agreements with TPAs to determine whether it is possible to opt out of cross-plan offsetting or limit the practice to in-network providers.
- Discuss with TPAs whether they offer assistance with potential litigation resulting from their use of cross-plan offsetting or have agreements with providers to not balance bill participants.
- 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 service agreements, please contact a member of our Employee Benefits and Executive Compensation group.

Summary of Selected Indexed Employee Benefit Related Limits

	2018	2019	2020	2021	2022	2023	2024	2025
Annual Elective Deferral Limits								
401(k), 403(b) and SEPs	18,500	19,000	19,500	19,500	20,500	22,500	23,000	**23,500**
457 plans	18,500	19,000	19,500	19,500	20,500	22,500	23,000	**23,500**
SIMPLE IRAs and 401(k)s	12,500	13,000	13,500	13,500	14,000	15,500	16,000	**16,500**
Catch-up Contributions (≥ age 50)								
401(k), 403(b), 457 and SEPs	6,000	6,000	6,500	6,500	6,500	7,500	7,500	**7,500**
SIMPLE IRAs and 401(k)s	3,000	3,000	3,000	3,000	3,000	3,500	3,500	**3,500**
Special Catch-up Contributions (ages 60–63)								
401(k), 403(b), and governmental 457(b)								**11,250**
SIMPLE IRAs and SIMPLE 401(k)s								**5,250**
Maximum Annual Compensation								
401(a)(17)	275,000	280,000	285,000	290,000	305,000	330,000	345,000	**350,000**
415 Maximum Annual Additions								
Defined benefit plan dollar limit	220,000	225,000	230,000	230,000	245,000	265,000	275,000	**280,000**
Defined contribution plan dollar limit	55,000	56,000	57,000	58,000	61,000	66,000	69,000	**70,000**
Highly Compensated Employees								
414(q)	120,000	125,000	130,000	130,000	135,000	150,000	155,000	**160,000**
Key Employees (Top Heavy)								
Officers	175,000	180,000	185,000	185,000	200,000	215,000	220,000	**230,000**
1% owner	150,000	150,000	150,000	150,000	150,000	150,000	150,000	**150,000**
Employee Stock Ownership Plans								
Five-year distribution threshold	1,105m	1,130m	1,150m	1,165m	1,230m	1,330m	1,380m	**1,415m**
Step-up	220,000	225,000	230,000	230,000	245,000	265,000	275,000	**280,000**
IRAs								
Annual contribution limit	5,500	6,000	6,000	6,000	6,000	6,500	7,000	**7,000**
Catch-up contributions (≥ age 50)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**1,000**
PBGC								
Monthly maximum guaranteed benefit	5,607.95	5,607.95	5,812.50	6,034.09	6,204.55	6,750.00	7,107.95	**7,431.82**
Annual maximum guaranteed benefit	65,045	67,295	69,750	72,409	74,455	81,000	85,295	**89,182**
Flat Premium Per Participant (single-employer)	74	80	83	86	88	96	101	**106**
Flat Premium Per Participant (multiemployer)	28	29	30	31	32	35	37	**39**
Transportation Fringe Benefits								
Employer-provided parking (monthly)	260	265	270	270	280	300	315	**325**
Mass transit pass & vanpool (monthly)	260	265	270	270	280	300	315	**325**
Social Security								
Taxable wage base	128,400	132,900	137,700	142,800	147,000	160,200	168,600	**176,100**

U.S. High Court To Hear Prohibited Transaction Case: *Cunningham v. Cornell*

On October 4, 2024, the U.S. Supreme Court granted certiorari in *Cunningham v. Cornell*, a case brought by participants in Cornell University's retirement plans. The Supreme Court's decision in this case will greatly impact the future landscape of ERISA litigation by establishing the standard required for participants to make a prohibited claim against plan fiduciaries.

Cunningham v. Cornell was originally filed in 2016 on behalf of over 28,000 Cornell University employees who alleged that the University's retirement plans offered too many investment options and had multiple recordkeepers. Plaintiffs alleged that these factors caused the plans to pay excessive recordkeeping fees, a prohibited transaction between the retirement plans and the recordkeepers.

In 2019, the U.S. District Court for the Southern District of New York dismissed all but one of the claims, which Cornell fiduciaries settled for $225,000. Plaintiffs' appeal of the dismissed claims was denied by the Second Circuit Court of Appeals in November 2023. The Second Circuit's decision is favorable to plan fiduciaries because it requires plaintiffs to allege that a fiduciary *caused* the plan to engage in a prohibited transaction for which no statutory or class exemption applies. This approach largely aligns with similar rulings out of the Third, Seventh, and Tenth Circuits in applying a heightened pleading standard for ERISA cases but conflicts with decisions in the Eighth and Ninth Circuits that merely require plaintiffs to plausibly allege that such a transaction *occurred*.

The Supreme Court has now agreed to resolve the Circuit split and will determine whether a plaintiff can maintain a claim solely by alleging that a transaction between the plan and a service provider occurred or whether additional facts, other than those expressly outlined under ERISA, will be required. The Supreme Court's resolution of this question will significantly impact the future landscape of prohibited transaction claims. A Supreme Court ruling that plaintiffs need only allege that a prohibited transaction *occurred* to survive a motion to dismiss will likely result in more ERISA class action cases, which are already increasing each year.

Since the outcome of the *Cunningham v. Cornell* case will have wide-reaching implications, please stay tuned to future Client Alerts on this issue from our Employee Benefits and Executive Compensation group.

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New Flurry of Litigation Challenging Wellness Programs

More than one dozen class action lawsuits were filed this year challenging wellness programs that increased group health plan premiums for participants who use tobacco. Employers should take steps to ensure their wellness programs are up-to-date and in compliance with federal law.

The Health Insurance Portability and Accountability Act ("HIPAA") nondiscrimination rules prohibit group health plans from charging higher premiums to participants based on any health factor unless certain exceptions are met. One exception is a compliant wellness program, which allows a plan to charge tobacco users a higher premium for their health plan as compared to non-tobacco users. This wellness program must meet specific requirements, including offering a reasonable alternative standard ("RAS") to avoid the surcharge, providing notices of the RAS, and making the full reward available if the RAS is met.

These tobacco surcharge lawsuits largely stem from alleged deficiencies in the RAS requirement or its implementation, including failing to provide the notice of a RAS in all plan materials, communicating misleading information regarding the RAS, failing to provide a RAS altogether, and failing to make the full wellness program reward available to individuals who complete the RAS.

This is not an unexpected development. Our prior publication from 2018 warned employers of the risks associated with administering wellness programs, including significant civil monetary penalties levied against plan sponsors and even against plan fiduciaries personally.

Specifically, employers should:

- Ensure the wellness program properly documents and includes all requirements, such as those under HIPAA, the ADA, and GINA;
- Review all surcharges to verify that participants are offered a RAS to earn the full reward (avoid the surcharge);
- Include information on the RAS in plan documents and participant communications related to the wellness program;
- Ensure participants are provided the opportunity to earn the wellness program reward (e.g., avoid the surcharge) at least once per plan year;
- Provide the full reward to participants who complete the RAS;
- Consider creating a fiduciary committee responsible for overseeing wellness programs offered in conjunction with the group health plan; and
- Review fiduciary liability insurance policies to ensure they cover fiduciaries of the wellness program.

If you have any questions related to tobacco surcharge litigation or these action items, or if you would like assistance in structuring your wellness program to comply with HIPAA and other applicable law, please contact a member of Kutak Rock's Employee Benefits and Executive Compensation group, including the ERISA Fiduciary and Benefits Litigation team.

Employer Guidance on Revising Evidence of Insurability Practices

The U.S. Department of Labor (the "DOL") has rolled out an initiative over the last two years to investigate insurance companies' practices surrounding Evidence of Insurability ("EOI") for life insurance benefits. These investigations have resulted in several settlements, which provide guidance for other insurance companies and employers to avoid similar legal consequences.

What Is Evidence of Insurability?

EOI is an application process that involves providing health and lifestyle information to an insurer, which is used to evaluate insurability risk. While the specific questions differ by carrier, common EOI data includes the prospective participant's age, physical attributes, personal details, employment and financial information, coverage details, medical conditions, and treatment history. Insurers will typically guarantee the issuance of life insurance at a certain threshold (the "guaranteed issue amount") but require an EOI process before underwriting benefits above this limit.

Insurers use this same process for employer-provided life insurance benefits—guaranteeing a certain amount of life insurance for each employee and requiring an EOI process for additional coverage. However, a recent trend in the life insurance industry is to collect the additional premium for higher insurance levels elected by employees even before the EOI process has been completed or the higher level of coverage was approved. This has resulted in some employees (or their beneficiaries) having benefit claims denied despite the dutiful payment of the premium owed for the increased benefits.

(Revising Evidence CONTINUED ON PAGE 10)

(Revising Evidence CONTINUED FROM PAGE 9)

U.S. Department of Labor Investigations

In 2024, the DOL entered into settlements with two major life insurance providers: Unum Life Insurance Company of America and Lincoln Life & Annuity Company of New York. These settlements followed numerous DOL investigations which concluded that collecting life insurance premiums through payroll deductions before confirming EOI requirements are satisfied is common in the insurance industry. These settlements followed nearly identical settlements in 2023 with Prudential Insurance Company of America ("Prudential") and United of Omaha Life Insurance Company. The DOL found that Prudential's use of this practice dated as far back as 2004.

As a result of these settlements, the insurers are prohibited from requesting EOI on coverage for which an employee has been paying premiums for more than a year. Further, the insurers cannot deny a claim for benefits based solely on the fact that EOI was not submitted or approved if the employee had been paying premiums for 90 days or more. Lastly, the insurers must refund all premiums received for coverage requiring EOI if the employee's claim is denied.

Impact on Employers and Preventative Action

The DOL also required the insurers to notify existing and new policyholders that premiums for coverage subject to an EOI requirement should not be collected from employees until approval is received. The notices must also state that failure to do so may result in the policyholder being liable to the employee or their dependents if their claim is denied.

While these settlement terms do not apply to every life insurance carrier, employers and insurers should still implement practices and procedures designed to communicate EOI approval in an accurate and timely manner. In the absence of further DOL guidance on this subject, case law is instructive. Courts have ruled that prudent fiduciaries must use a system that avoids the employer and insurer having different lists of eligible, enrolled participants. A reasonable method of accomplishing this includes the employer providing a list of employees believed to have valid EOI, having the insurer review this list, and providing a weekly status report that indicates which employees are approved and which still need to submit EOI. The insurer should also notify the employer when employees are approved.

If you have any questions about evidence of insurability and how it affects your group health plans or need assistance reviewing and negotiating the plan documents or insurance contracts, please contact a member of our Employee Benefits and Executive Compensation group.

Action Items for Plan Sponsors

In light of the DOL's increased focus on EOI, plan sponsors should re-evaluate the EOI approval procedures applicable to their plans. Additionally, plan sponsors should:

- Ensure that premiums for coverage above the guaranteed issue amount are not being collected from an employee before their EOI is approved by the plan's insurer.
- Consider implementing administration platforms programmed to collect premiums only up to the guaranteed issue amount while the employee's EOI approval is pending.
- Improve or revise the practices and procedures used for communicating EOI approvals between the plan and its insurer.
- Inquire about EOI communication procedures when contracting with insurers.

Summary of Selected Health & Welfare Benefit Plan Limits

	2018	2019	2020	2021	2022	2023	2024	2025
Health Savings Account (HSA) Contributions[1]								
Contribution limit – individual coverage	3,450	3,500	3,550	3,600	3,650	3,850	4,150	**4,300**
Contribution limit – family coverage	6,900	7,000	7,100	7,200	7,300	7,750	8,300	**8,550**
Catch-up contributions (≥ age 55)	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**1,000**
High-Deductible Health Plan (HDHP): Minimum Deductible[1]								
Individual coverage	1,350	1,350	1,400	1,400	1,400	1,500	1,600	**1,650**
Family coverage	2,700	2,700	2,800	2,800	2,800	3,000	3,200	**3,300**
HDHP – Out-Of-Pocket Maximum[1]								
Individual coverage	6,650	6,750	6,900	7,000	7,050	7,500	8,050	**8,300**
Family coverage	13,300	13,500	13,800	14,000	14,100	15,000	16,100	**16,600**
Health Flexible Spending Arrangements (FSAs)[2]								
Contribution limit	2,650	2,700	2,750	2,750	2,850	3,050	3,200	**3,300**
Maximum carryover limit	500	500	550	550	570	610	640	**660**
Affordable Care Act								
PCORI Fee[3]								
	2.39 pp	2.45 pp	2.54 pp	2.66 pp	2.79 pp	3.00 pp	3.22 pp	**3.47 pp**
ACA Employer-shared Responsibility Payments (a.k.a. "assessable payments" or penalties)[4]								
Code § 4980H(a)	2,320	2,500	2,570	2,700	2,750	2,880	2,970	**2,900**
Code § 4980H(b)	3,480	3,750	3,860	4,060	4,120	4,320	4,460	**4,350**
Out-of-Pocket Limit (Non-Grandfathered)[5] ^								
Individual	7,350	7,900	8,150	8,550	8,700	9,100	9,450	**9,200**
Family	14,700	15,800	16,300	17,100	17,400	18,200	18,900	**18,400**
Group Health Plan Affordability								
Federal Poverty Line (FPL)* – Single Individual[6]	12,060	12,140	12,490	12,760	12,880	13,590	14,580	**15,060**
Affordability Percentage[7] **	9.56%	9.86%	9.78%	9.83%	9.61%	9.12%	8.39%	**9.02%**

^ HDHPs must comply with both the ACA and HDHP limits.
* FPL for mainland United States (does not include AK or HI).
** Applies to determining the affordability of offered minimum essential coverage using household income or an affordability safe harbor.

Sources: [1] Rev. Proc. 2024-25 [2] Rev. Proc. 2024-40 [3] Rev. Proc. 2024-83 [4] Rev. Proc. 2024-14 [5] HHS Notice of Benefit and Payment Parameters (11/15/2023) [6] HHS Poverty Guidelines [7] Rev. Proc. 2024-35

Plan Sponsor Considerations for In-Plan Annuity Offerings

Last year's newsletter included an article generally describing the initial compliance considerations when annuity options are added to a defined contribution plan. As predicted, we have seen a sharp increase in insurers actively reaching out to plan sponsors and retirement committees to present information on their annuity products. This article expands on last year's article to explain the safe harbor requirements for annuity offerings, which vary depending on the type of annuity selected and the manner in which it is offered.

Annuities in a Nutshell

Annuities vary in structure—fixed versus variable, immediate versus deferred, single life versus joint-and-survivor—but all annuities essentially provide guaranteed payments later in exchange for money today. Annuities offer tax benefits, certain value payments, and guaranteed rates of return but are also complex, relatively illiquid, and expensive. However, in-plan annuity options are usually less expensive than individually purchased annuities.

With **fixed annuities**, a *minimum* payout is guaranteed for the full distribution term when the first contribution is made, and an *actual* payout becomes guaranteed once distributions begin (immediate annuity) or the future distribution date is set (deferred annuity). The value of the payout is based on the account value used to purchase the annuity or the amount of premium collected plus a predetermined interest or crediting rate methodology.

In contrast, the payment streams in **variable annuities** are not guaranteed at the time of purchase because the crediting rate formulas used to calculate the payments are linked to an underlying investment

(In-Plan Annuity Offerings CONTINUED ON PAGE 12)

(In-Plan Annuity Offerings CONTINUED FROM PAGE 11)

with variable rates of return. Variable annuities can offer a **guaranteed lifetime withdrawal benefit** for a fee, which sets a guaranteed minimum payout at the time of purchase while still maintaining the potential upside from market returns.

Plan Sponsor Considerations

Retirement plan sponsors are not required to add any *particular* product, including an annuity, to a retirement plan menu, so the decision to offer (or not) an annuity product is subject to the general fiduciary duties in ERISA requiring fiduciaries to discharge their duties with loyalty and prudence, among other things. Additional fiduciary considerations arise that vary depending on the type of annuity offered and how it is offered.

Safe Harbor for Selection of Annuity Providers

When a plan fiduciary selects an insurer to offer a fixed-term or lifetime annuity, the fiduciary meets their duty of prudence if they:

- Search objectively, thoroughly, and analytically to identify and select an annuity provider.
- Consider the financial capability of the annuity provider to satisfy its obligations under the annuity contract, which means obtaining certain written representations (e.g., the insurer is licensed to offer annuities, it has filed audited financial statements, it maintains sufficient reserves, it undergoes a financial examination at least once every five years).
- Weigh the costs of the annuity contract (e.g., fees, commissions, surrender penalties) against the benefits and services to be provided. There is no requirement to choose the lowest-cost annuity.
- Conclude that, at the time of the selection, the annuity provider is financially capable of satisfying its future payment obligations under the annuity contract and the relative cost of the annuity contract is reasonable in relation to the benefits and services to be provided under the contract.

If, after considering these items, a plan fiduciary elects to add an annuity option to the plan's investment lineup, the fiduciary must also *monitor* the annuity provider through annual disclosures. If these conditions are met, the plan fiduciary is relieved of all liability for losses that may result from an insurer's inability to pay the promised annuity benefits.

Other Safe Harbors

ERISA Section 404(c)(1) provides a liability safe harbor for plan fiduciaries in participant-directed plans. To qualify for this safe harbor, the plan must, among other things, provide a participant or beneficiary an opportunity to exercise control and choose their investments from a broad range of investment options and provide sufficient disclosures to enable informed decisions. Section 404(c)(5) of ERISA also provides a safe harbor for a fiduciary that implements an appropriate Qualified Default Investment Alternative ("QDIA") in their participant-directed plans, such as a balanced fund, model portfolio, or target date fund, but can also include unallocated deferred annuity contracts as standalone fixed income investments or as a component of another investment product. As with other safe harbors, plan fiduciaries are relieved of liability for participant losses in QDIA investments, provided they meet certain disclosure and notice obligations and otherwise fulfill duties under ERISA.

Plan fiduciaries must therefore understand how the annuity component operates in the plan. For example, if the plan defaults its older participants into annuity contracts, the plan sponsor must evaluate the investment under both the annuity selection safe harbor and the QDIA regulation requirements. However, if the selected QDIA merely includes annuities as an embedded component of the overall investment holdings and the investment as a whole is managed by an investment manager (as described in Section 3(38) of ERISA) with discretion to select the component annuities, the fiduciary consideration is to prudently select and monitor the investment manager, which in turn will select and monitor the annuity provider in accordance with the annuity selection safe harbor conditions.

Finally, a plan with a self-directed brokerage window feature may permit participants to elect to allocate account assets to investments beyond those contained in the plan's investment menu, including individual securities, mutual funds, bonds, ETFs, options and annuities. The Department of Labor has provided little guidance to plan sponsors evaluating and selecting these arrangements apart from confirming that the same fiduciary duties of loyalty and prudence apply as when selecting other plan services. Thus, plan sponsors should consider their monitoring obligations if their brokerage advisors are recommending that participants roll over, transfer or distribute account assets from the plan to an outside annuity and understand how those obligations will be impacted by changes in the law (e.g., the changes to the Retirement Security Rule, which are currently on hold).

Plan fiduciaries who are considering adding or have annuity offerings must understand their initial and ongoing fiduciary and compliance duties, which will require expert investment, actuarial, and legal advice. If you have questions about annuities and how fiduciaries should conduct their review of available annuity products, please reach out to a member of our Employee Benefits and Executive Compensation group.

Public Employers May Want To Review Long-Term Plans in Preparation for Expansion of "Covered Employees" Under Code Section 162(m)

Section 162(m) of the Internal Revenue Code provides that public companies may not take a tax deduction for certain employee compensation in excess of $1 million during the company's taxable year. This restriction applies only to compensation paid to "Covered Employees," and that classification is set to expand for tax years after December 31, 2026.

Currently, the definition of "Covered Employees" generally includes only the company's named executive officers. However, for tax years beginning on or after January 1, 2027, the definition will expand to include the next five highest-compensated employees. Although this expanded definition does not go into effect for several years, public companies should still begin planning now for this expansion in relation to long-term incentive awards. Specifically, companies may want to consider structuring these awards to vest prior to the application of the expanded definition for individuals who could be covered under the expansion, thus avoiding the lost tax deduction.

If you have questions about who qualifies as a Covered Employee or other executive compensation matters, contact a member of our Employee Benefits and Executive Compensation group.

2024 Hot Topics for Apprenticeship Funds

Developments in 2024 affecting jointly administered apprenticeship funds, ("JATCs"), include proposed apprenticeship regulations, mental health of apprentices, and new cybersecurity guidelines.

Developments in 2024 affecting jointly administered apprenticeship funds, sometimes referred to as Joint Apprenticeship Training Committees ("JATCs"), include proposed apprenticeship regulations, mental health of apprentices, and new cybersecurity guidelines.

1. Proposed Apprenticeship Regulation Overhaul

On January 17, 2024, the Department of Labor ("DOL") published a proposed rule with major changes to the regulations that govern DOL-registered apprenticeship programs. If finalized as currently written, the regulation will change as follows:

- JATCs must provide each apprentice with at least 144 hours of classroom instruction for every 2,000 hours of on-the-job training.
- Apprenticeship programs would have additional recordkeeping requirements and must allow their Registration Agency access to those records.
- Pre-apprenticeship programs must register and provide information to the DOL.
- Apprenticeship agreements must contain certain terms, such as detailed provisions regarding the wage scale, the minimum number of hours for on-the-job training, a description of benefits, a breakdown of unreimbursed costs and more. The agreement must be cancelable by the apprentice "at any time" or by the "program sponsor *only for good cause*" (emphasis added).

JATC fiduciaries and plan sponsors should closely monitor the status of this proposed rule, as substantial changes are expected in the final version.

2. Mental Health

As with other industries, the building trades have seen a rise in demand for mental health services; the Centers for Disease Control and Prevention reports that construction and mining workers are more likely to die by suicide or opioid overdose than workers in other professions.

JATCs address these problems by referring apprentices to community services offered by the union, participating employer, or ancillary training program. JATCs can employ the following best

(Hot Topics CONTINUED ON PAGE 14)

(Hot Topics CONTINUED FROM PAGE 13)

practices when assisting apprentices with mental health issues and instilling a culture of mental health awareness:

- Partnering with in-network mental health professionals to offer information and educational sessions related to mental health issues.
- Offering a mental health course that informs apprentices on the available resources and encourages their use as part of the onboarding curriculum.
- Implementing employee assistance programs offering short-term counseling, mental health assessments and stress management, as well as facilitating referrals or follow-up services.

In addition, JATCs should enact policies and procedures regarding mental health to ensure that the JATC and its staff are prepared to handle mental health incidents and the associated protected health information generated in addressing mental health incidents and treating mental health disorders.

3. Cybersecurity

In 2021, the DOL's Employee Benefits Security Administration ("EBSA") issued guidance to retirement plans, detailing cybersecurity best practices. On September 6, 2024, EBSA issued additional guidance stating that these best practices now should be implemented by all employee benefit plans, including JATCs (which are welfare plans under ERISA).[1] This can be problematic, as many JATCs do not have the means to enact some of the more costly best practice recommendations.

EBSA provided six tips for hiring service providers that focus on evaluating the service provider's cybersecurity practices, such as information security and breach notification processes. The guidance also includes contract provisions JATCs should be looking for in their service provider agreements, including requiring insurance, defining how participant data will be used, and avoiding language that limits service provider liability for breaches.

The Cybersecurity Program Best Practices provides 12 best practices that now clearly apply to JATCs since most JATCs are self-administered and house most of their own data. The best practices recommend having a well-documented cybersecurity program, conducting cybersecurity training and risk assessments, encrypting sensitive data, and following a cybersecurity incident response plan.

The Online Security Tips include a standard compilation of best practices for reducing risk of fraud, including setting complicated passwords, removing inactive account users, avoiding free wireless Internet hotspots, and implementing multifactor authentication.

If you have any questions about new apprenticeship developments or would like assistance implementing best practices or creating new processes for evaluating service providers, please contact a member of our Employee Benefits and Executive Compensation group.

1. https://www.dol.gov/newsroom/releases/ebsa/ebsa20240906-0

New Trend of Health and Welfare Fiduciary Litigation

As discussed in our prior publication, because individuals can now review the amount a plan pays for various services and compare that information to other plans, health plan fiduciaries could be at risk if they fail to determine whether their plans' vendor arrangements reflect market pricing. A recent litigation trend underscores this risk.

Lewandowski v. Johnson & Johnson

The plaintiffs, participants of Johnson & Johnson's ("JNJ") health plan, allege that JNJ and plan fiduciaries breached their fiduciary duties in selecting and failing to monitor JNJ's agreement with a pharmacy benefit manager ("PBM") and consultants. The agreement allegedly allowed the PBM to charge the plan "extraordinary" costs for numerous drugs as compared to other market options and unnecessarily cost the plan millions of dollars. Plaintiffs seek to hold JNJ's fiduciaries *personally* liable for not paying the lowest possible cost for every drug offered by the plan.

Navarro v. Wells Fargo

The plaintiffs filed a class action complaint in July 2024, alleging Wells Fargo and its plan fiduciaries engaged in prohibited transactions by agreeing to pay their PBM excessive administrative fees relative to market rates, a breach of their ERISA fiduciary duties. Plaintiffs seek to hold Wells Fargo and its fiduciaries responsible for the plan's losses, to have the fiduciaries removed, and to have the PBM replaced by another vendor.

Status of Litigation

It is unclear whether these cases will proceed beyond the initial stages. A similar case, *Knudsen v. MetLife*, was recently dismissed because the court concluded that the plaintiffs failed to demonstrate they were personally harmed by the plan's losses. Regardless of the result in *Lewandowski*, *Navarro*, and other similar lawsuits, this litigation trend will likely continue and evolve. Employers and plan fiduciaries should take steps to help reduce their litigation exposure.

(Fiduciary Litigation CONTINUED ON PAGE 15)

(Fiduciary Litigation CONTINUED FROM PAGE 14)

Action Items for Plan Sponsors

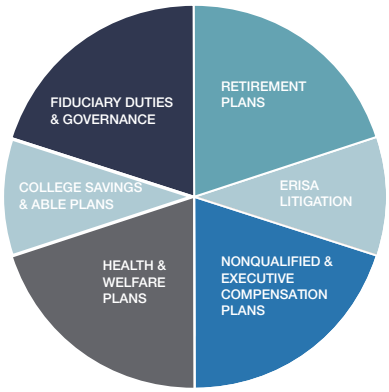
Plan sponsors should consider establishing fiduciary committees to oversee their health and welfare benefits. Such fiduciary committees should:

- Create policies and procedures for selecting vendors, negotiating service agreements, and monitoring vendor performance.
- Collect and review benchmarking data from other plans and compare those to proposed vendor arrangements for market reasonability.
- Periodically subject vendors to requests for proposals.
- Engage qualified plan consultants to assist in comparing vendors and ensure consultants and vendors do not have conflicts of interest.
- Consider whether any direct or indirect compensation arrangements are reasonable or whether there are any conflicts of interest.
- Request and review agreements, fee arrangements, and prescription drug formularies and actively negotiate favorable terms.
- Document the policies and procedures used to obtain, review, and monitor proposals, agreements, benchmarking information, vendor performance, and steps taken to demonstrate procedural prudence in administering health and welfare benefits.

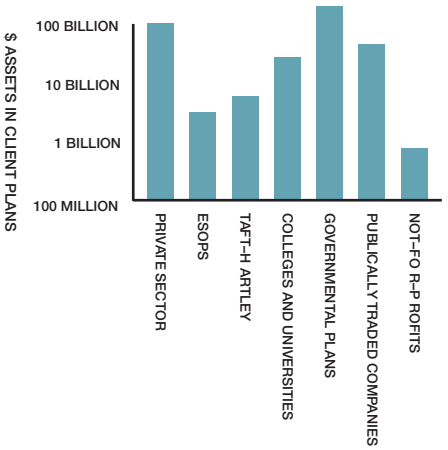
If you have questions about fiduciary governance or these action items, please contact a member of Kutak Rock's Employee Benefits and Executive Compensation group, including the ERISA Fiduciary and Benefits Litigation team.

About Us

What We Do



Who We Represent



Where We Are

In Case You Missed It

November 8, 2024 | 2024 Election Brings More Workers Paid Sick Leave Laws in Nebraska, Missouri, and Alaska

September 25, 2024 | New Mental Health Parity Rules Require Plans and Employers to Take Action

September 9, 2024 | U.S. Department of Labor Updates Cybersecurity Guidance for ALL Employee Benefit Plans

August 6, 2024 | Lawsuit Against Wells Fargo Highlights Increasing Focus on Health and Welfare Plan Fiduciaries

April 30, 2024 | New HIPAA Rules Limit the Use and Disclosure of PHI Related to Reproductive Health Care and Revise Notice of Privacy Practices Requirements

February 12, 2024 | Johnson & Johnson Litigation Highlights Significant Risks for Health and Welfare Plan Fiduciaries

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