Benefits Counselor – March 2023

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RETIREMENT PLAN DEVELOPMENTS

IRS Publishes Proposed Regulations Regarding Use of Forfeitures

On February 27, 2023, the Internal Revenue Service (IRS) published proposed regulations regarding the use of forfeitures in qualified retirement plans. In particular, the regulations provide welcome clarity regarding the deadline by which forfeitures under a defined contribution plan must be used. The proposed effective date of the regulations is plan years beginning on or after January 1, 2024, but plan sponsors may rely upon the proposed regulations immediately.

Defined Contribution Plans

- The proposed regulations require that plans use forfeitures no later than 12 months after the close of the plan year in which the forfeitures are incurred. However, the proposed regulations include transition relief, which would allow plans to treat forfeitures incurred prior to the start of the 2024 plan year as being incurred during the 2024 plan year.
- The proposed regulations provide that forfeitures may be used for one or more of the following purposes, if authorized in the plan document: (1) to pay plan administrative expenses; (2) to reduce employer contributions under the plan; and (3) to increase benefits in other participants' accounts according to plan terms. The use of forfeitures to reduce employer contributions includes the restoration of inadvertent benefit overpayments and conditionally forfeited accounts that might otherwise require additional employer contributions.
- The proposed regulations advise plan sponsors to be mindful that not using forfeitures prior to the 12 month deadline will result in an operational failure and suggest that plan sponsors consider amending plan documents to permit multiple uses of forfeitures.

Defined Benefit Plans

- The proposed regulations would update rules relating to the use of forfeitures in defined benefit plans to reflect the enactment of new minimum funding requirements. Additionally, the requirement that forfeitures under pension

plans be used as soon as possible to reduce employer contributions would be eliminated, as it is inconsistent with the minimum funding requirements.

Tenth Circuit Holds Plan Arbitration Provision Violates ERISA

On February 9, 2023, the U.S. Court of Appeals for the Tenth Circuit issued its opinion in *Harrison v. Envision Management Holding, Inc. Employee Stock Ownership Plan Committee*, holding that an arbitration provision included in an ESOP violated the Employee Retirement Income Security Act of 1974 (ERISA). The plaintiff, Robert Harrison, filed the case against the plan's fiduciaries on behalf of himself and similarly situated participants, alleging that the plan's fiduciaries breached their fiduciary duties under ERISA. Harrison's complaint sought plan wide relief on behalf of the ESOP.

The defendants then moved to compel arbitration, arguing that a provision of the plan document waived the right of participants to bring class actions and required arbitration of Harrison's claims. The provision prohibited participants from seeking or receiving any remedy which had the effect of providing additional benefits or other relief to other participants. In a response brief, Harrison argued that ERISA explicitly guarantees the right of plan participants to seek relief on behalf of the plan as a whole. As a result, he argued, the arbitration provision could not be enforced because it stripped him of substantive rights conferred by ERISA. The district court ruled in Harrison's favor and denied the motion. The defendants appealed the decision to the Tenth Circuit.

The Tenth Circuit affirmed the district court's ruling, emphasizing that the provision was problematic, not because it required arbitration of claims, but because it foreclosed several remedies specifically authorized by ERISA. These remedies include the right of participants to be made whole for losses resulting from fiduciary breaches and the removal of plan fiduciaries.

In support of its decision, the Tenth Circuit noted the U.S. Court of Appeals for the Seventh Circuit's decision in *Smith v. Board of Directors of Triad Manufacturing*, which involved similar facts and an almost identical arbitration provision. In *Smith*, the Seventh Circuit held that the arbitration provision at issue conflicted with ERISA but specifically focused on a participant's right to seek the removal of a plan fiduciary. The *Harrison* opinion demonstrates that taking the logic of *Smith* to its final conclusion means that provisions that prohibit plan wide remedies, including monetary remedies, will likely be found in violation of ERISA. Sponsors of plans that include arbitration provisions should carefully consider the two

cases to determine if their language will hold up to judicial scrutiny.

HEALTH AND WELFARE PLAN DEVELOPMENTS

Texas Court Vacates Portions of Surprise Billing IDR Regulations

On February 6, 2023, the U.S. District Court for the Eastern District of Texas vacated portions of the final regulations that implemented the surprise billing independent dispute resolution (IDR) provisions of the No Surprises Act portion of the Consolidated Appropriations Act, 2021 (CAA). The decision is the latest chapter in an ongoing legal battle between the U.S. Department of Health and Human Services (HHS) and trade associations for medical providers regarding the factors to be considered during the IDR process. In response to the decision, HHS has directed IDR entities to cease processing payment determinations for services furnished on or after October 25, 2022.

Background

The ongoing dispute began with the passage of the No Surprises Act, which group health plans, insurers and out of network providers who cannot agree on the appropriate price for certain services furnished to a participant to submit the dispute to an IDR entity for arbitration. The No Surprises Act requires both parties to submit a proposed payment amount and explanation to the arbitrator, who must then select one of the two proposed amounts based on numerous factors listed in the law, including the provider's level of training, experience, market share, patient acuity and "qualifying payment amount" (QPA). Generally, the QPA is based on the plan's median in network rate.

Legal Challenge to Interim Regulations

Following the passage of the No Surprises Act, the HHS, along with the U.S. Department of Labor (DOL) and IRS (collectively, the Agencies), published interim regulations to implement the IDR process. The interim regulations created a rebuttable presumption that the proposed payment amount closest to the QPA was the proper amount. The Texas Medical Association (Association), a trade association representing thousands of Texas based physicians, then sued to overturn the interim regulations, arguing they required IDR entities to give "outsized weight" to a single statutory factor, the QPA, in conflict with the No Surprises Act. Agreeing with the Association in a February 2022 opinion, the U.S. District Court for the Eastern District of Texas vacated the portions of the interim regulations that prioritized the QPA over other factors during the IDR process.

Following the decision, the Agencies finalized the regulations, but only after removing the invalidated portions. The final regulations instructed IDR entities to consider the QPA when making a determination, but no longer provided that the QPA was the appropriate out of network rate. The final regulations also stated that IDR entities should consider all permissible information submitted by the parties.

Legal Challenge to Final Regulations

Following publication of the final regulations, the Association again filed suit in the Eastern District of Texas. The Association argued that even without the vacated language, the final regulations continued to place an "outsized weight" on the QPA and impermissibly limited the arbitrator's ability to exercise discretion when evaluating claims. For example, the final regulations instructed arbitrators to evaluate whether all factors besides the QPA were "credible" but presumed the QPA would be credible. The court again held in the Association's favor and vacated the final regulations in a February 6, 2023, ruling.

In response to the ruling, on February 10, 2023, HHS instructed all IDR entities to cease issuing new payment determinations until further notice. On February 24, 2023, HHS announced that IDR entities could resume processing determinations relating to services furnished before October 25, 2022, because these services were unaffected by the recent opinion. However, determination processes for services provided on or after October 25, 2022, remain frozen pending further guidance from HHS.

Agencies Publish FAQs Regarding Gag Clause Prohibition

On February 23, 2023, the Agencies published a set of frequently asked questions (FAQs) addressing the CAA's prohibition of "gag clauses" in group health plan agreements. As clarified in the FAQs, a gag clause is a contractual term that directly or indirectly restricts information a plan or other issuer can make available to another party. The CAA specifically prohibits gag clauses regarding provider specific cost or quality of care information, as well as access to de identified claims data. Examples of prohibited gag clauses in the FAQs include a clause stating a third party administrator (TPA) will not disclose provider rates because it considers them proprietary information and a clause stating that the TPA will only allow access to quality-of-care information at its discretion.

The FAQs provide additional information on when and how plans should submit the annual attestation of compliance with the gag clause prohibition. The first

attestation will cover the period from December 27, 2020, through the date of attestation, and is due by December 31, 2023. Going forward, the annual attestation will be due by December 31 of each calendar year.

The requirement will cover each of the following, regardless of whether the plan is grandfathered under the Affordable Care Act (ACA): (1) ERISA plans; (2) non federal governmental plans; and (3) church plans subject to the Internal Revenue Code. Attestation will not be required for excepted benefits. The FAQs state that the Agencies will not enforce the attestation requirement against plans which consist solely of health reimbursement arrangements or other account based group health plans. Self insured plans may contract to have a service provider, such as a TPA, submit the attestation on their behalf. The yearly attestations are to be submitted online through the Centers for Medicare & Medicaid Services' (CMS) Health Insurance Oversight System (HIOS).

CMS Extends Deadline for Publication of Final Regulations Regarding MSP Reporting Violations

On February 27, 2023, CMS announced that it was extending the deadline for publication of final regulations regarding monetary penalties for violations of the Medicare Secondary Payer (MSP) reporting requirements. The MSP statutes provide CMS with significant discretion in determining whether an entity required to make reports under the statute should be fined for failure to comply. CMS published proposed regulations in February 2020 that aimed to clarify when it would assess monetary penalties and how those would be calculated. The proposed regulations provided that CMS would finalize the regulations within three years.

CMS now states the new deadline for publication of the final regulations is February 18, 2024. CMS noted the extension was necessary due to the agency's resources being diverted to the COVID 19 crisis. Additionally, CMS stated that it is researching the potential economic impact of the proposed regulations after concerns were raised during public listening sessions.

GENERAL DEVELOPMENTS

Agencies Announce Changes for the 2023 Form 5500 and Form 5500-SF

On February 23, 2023, the DOL, the IRS and the Pension Benefit Guaranty Corporation (PBGC) published two Federal Register Notices announcing changes to the Form 5500 Annual Return/ Report of Employee Benefit Plan and Form 5500 SF Short Form Annual Return/ Report of Small Employee Benefit Plan

effective for reporting plan years beginning on or after January 1, 2023. Many of the changes relate to provisions of the Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act) and the SECURE 2.0 Act of 2022. Previously proposed changes include moving participating employer information reported for certain multiple employer welfare arrangements from Form 5500 to Form M 1, and deferring changes to the schedule of assets as part of a broader project focused on improving group health plan reporting.

Highlights of the changes include the following:

- Funding and Financial Reporting by Defined Benefit Plans. Schedule R and Schedule SB will be revised to further improve defined benefit plans' financial and funding reporting by requesting additional data from defined benefit plans on Schedules MB, SB and R.
- Schedule H Changes. The revised Schedule H will include breakout categories for administrative expenses to allow for greater transparency of plan expenses.
- Participant Count Methodology for Defined Contribution Plans. The revised forms change the counting methodology for determining the 100 participant threshold for certain small plan simplified reporting alternatives. The counting methodology for defined contribution plans will be based on the number of participants with account balances, rather than the current method of counting individuals eligible to participate regardless of whether they have elected to participate.
- IRS Compliance Questions. The revised version of Schedule R and new Schedule DCG include questions regarding IRS compliance, such as: (1) whether the employer aggregated plans for purposes of nondiscrimination testing and whether the plan satisfied all applicable nondiscrimination tests; (2) whether the plan sponsor used a design based safe harbor approach or the "prior year" or "current year" Average Deferral Percentage (ADP) tests; and (3) whether the plan used a preapproved plan document.
- Consolidated Reporting by DCGs. The guidance introduces a filing option for a new type of direct filing entity called a defined contribution group (DCG) and a new Schedule DCG to report individual plan information. The new arrangement allows plan administrators of DCGs to file a single aggregated Form 5500. DCGs will generally be subject to the Form 5500 requirements for large pension plans. Large plans in a DCG arrangement and small plans that do not qualify for audit waiver will still be subject to a separate plan level audit by an independent

qualified public accountant as if they were filing separately. DCGs are not required to use a single trust (as had been previously proposed) but are required to use a single trustee.

- Reporting by MEPs. The revised forms will now call for additional data items relevant to multiple employer plans (MEPs) and create a new Schedule MEP to report information specific to MEPs.

IRS and Treasury Publish Final Regulations Expanding Mandatory E-Filing

On February 21, 2023, the U.S. Department of the Treasury and the IRS issued final regulations amending the rules for filing returns and other documents electronically (e file). The regulations significantly lower the threshold for required electronic filing of several tax return forms. Beginning with filing that is required to be reported in 2024, entities that file ten or more of the following returns will be required to do so electronically: Form W 2 Series, Form 1099 Series, Form 1094 Series, Forms 1095 B and 1095 C Series, Form 5330, Form 8955 SSA and the Form 5500 Series.

In some cases, filers must aggregate returns across return types to determine if they meet the ten return threshold. The aggregation rules are complex, and filers should carefully consider them before deciding whether to e file.

The regulations provide that the IRS may grant a waiver from the e filing requirements if an entity can demonstrate that complying with the regulations would create an undue hardship. The regulations further provide that the IRS may allow exemptions from the e filing requirements.

UPCOMING DEADLINES AND REMINDERS

RETIREMENT PLANS

Form 1099 R. Plans must e file Forms 1099 R with the IRS by March 31, 2023.

RMDs. Plans must begin to pay initial Required Minimum Distribution (RMD) payments by April 1, 2023.

Annual Funding Notice. Calendar year defined benefit plans with more than 100 participants must provide the Annual Funding Notice (AFN) by May 2, 2023 (later than usual due to April 30 falling on a weekend).

HEALTH AND WELFARE PLANS

ACA Information Reporting. If e filing, plan sponsors and applicable large

employers (ALEs) must file the transmittal Forms 1094 B and 1094 C, along with their corresponding Forms 1095, with the IRS by March 31, 2023.