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Mental Health Parity: Departments Release Proposed Rules to Strengthen MHPAEA Compliance

By Kate Belyayeva

In an effort to expand access to mental health care, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as amended by the Affordable Care Act, was signed into law to prohibit group health plans or health insurance issuers from imposing more restrictive quantitative treatment limitations ("QTLs") and nonquantitative treatment limitations ("NQTLs"), as written and in operation, on mental health or substance abuse disorder ("MH/SUD") benefits as compared to medical/surgical ("M/S") benefits in the same classification. In general, the MHPAEA aims at ensuring that the financial requirements and treatment limitations placed on MH/SUD benefits, if any, are not more restrictive than M/S benefits.

Section 203 of Title II of Division BB of the Consolidated Appropriations Act of 2021 (the "CAA") amended the MHPAEA to require group health plans and health insurance issues to perform and document their comparative analyses of the design and application of QTLs and NQTLs. This provision also requires the Secretaries of the Departments of the Treasury, Health and Human Services ("HHS"), and the Department of Labor ("DOL") (collectively, the "Departments") to report to Congress annually on the results of the NQTL comparative analyses reviews conducted by the Departments.

Congressional Report

In July 2023, the Departments provided the annual MHPAEA Comparative Analysis Report to Congress (the "2023 Report"). In prior years, the Departments outlined various enforcement efforts, findings, and results, and provided an overview of the existing guidance to develop a roadmap to compliance. The 2023 Report sheds light on the Departments' enforcement efforts in light of the CAA amendments to the MHPAEA and discusses the most common deficiencies in NQTL comparative analyses up to date. The Departments' guidance also includes proposed regulations (further discussed below), an enforcement fact sheet, and a compendium/appendix of MHPAEA guidance to-date. As required by the CAA, the 2023 Report also provides

a list of non-compliant plans and issuers. The full text of the 2023 Report can be found here.

Even though the MHPAEA has been in place for almost 15 years, some people continue experiencing great barriers to access MH/SUD care, which was described by the Departments as "a mental health and substance abuse disorder crisis that worsened during the COVID-19 pandemic." Between February 2021 and July 2022, more than 200 letters were used to request over 450 NQTL comparative analyses from plans and issuers. Some promising results have been noted: 104 plans and issuers agreed to make prospective changes to their plans, which would impact over 4 million participants and their beneficiaries over 39,000 plans.

Nevertheless, in the 2023 Report, the Departments communicated their continuous dissatisfaction with the recently received NQTL comparative analyses, despite the multiple rounds of insufficiency letters in some cases. Reasons for the NQTL comparative analyses falling short vary from not reporting sufficient information both quantitatively and qualitatively to not commencing the analysis until after the DOL's inquiry. Since February 2021, the DOL has issued more than 50 initial noncompliance determinations. Further, in the 2023 Report, the DOL noted exclusions of the following key MH/SUD treatments: nutritional counseling for eating disorders and medication-assisted treatment of opioid use disorder. In order to bridge the gap, the Departments sought to describe the information to be included and the timing for when to provide the NQTL comparative analysis.

Technical Release 2023-01P and NPRM

In connection with the 2023 Report, the DOL issued the related Technical Release 2023-01, which describes the principles surrounding the required data to be collected and evaluated by group health plans and health insurance issuers for NQTL comparative analyses. The Release also seeks public comments on the notice of proposed rulemaking ("NPRM") concurrently released by the Departments, entitled *Requirements Related to the Mental Health Parity and Addiction Equity Act*. The NPRM can be found here.

Among other things, the NPRM aims to address the following:

- "the type, form, and manner of the data the plans and issuers would be required to collect and evaluate";
- new and existing examples on the application of the applicable regulations; and
- "a potential enforcement safe harbor for plans and issuers that include data in their comparative analyses that demonstrate they meet or exceed all the standards with respect to NQTLs related to network composition, for a specified period of time."

As for the relevant data to be collected and evaluated, the Departments outlined four specific types of data: (1) out-of-network utilization; (2) percentage of in-network providers actively submitting claims; (3) time and distance standards; and (4) reimbursement rates. To this end, the preamble to the NPRM noted that "[a] key component of access is the availability of an adequate number of appropriate providers within a plan's network." The focus is mainly on the disparity of in-network reimbursement rates for primary care providers versus providers of MH/SUD benefits.

In addition, the Departments suggested implementing a requirement for a third-party administrator ("TPA") or other service provider to collect and evaluate the data in the aggregate for all plans or policies for all four types of data. The Departments recognized that obtaining the required data has been one of the greater challenges posed by the NQTL comparative analysis requirement. As such, the Departments requested comments on how the difficulty in obtaining the information from all the entities involved may be alleviated in hopes of improving compliance with the MHPAEA. The Departments specifically included a list of questions that are of particular interest. The comments to the NPRM are due 60 days after they are published in the Federal Register, which is yet to happen. Although the public comment period has not begun,

mental health stakeholders have been generally receptive of the proposed rules with some lingering concerns.

Employer Impact

Given the fact that the new requirements are only proposed, there are no immediate mandatory actions for employers. However, one thing is for certain—employers may expect a heightened focus on employer compliance related to mental health parity in the foreseeable future. The NPRM signals a continued effort on behalf of the Biden administration to eliminate any arbitrary barriers to mental health and substance abuse treatment. Therefore, employers should take some time to review their current limits on MH/SUD benefits in light of the recent enforcement efforts. Specifically, employers should consider what changes would be required starting in 2025 if the new requirements set forth in the NPRM were to be finalized, including an analysis of network adequacy.

Biden Administration Issues Proposed Rules on Short-Term Limited-Duration Health Insurance

By Claire Martin

The Department of Health and Human Services ("HHS), the Department of Labor, and the Department of the Treasury (collectively, the "Departments") recently released proposed rules regarding short-term limited-duration health insurance ("STLDI"), which narrow the definition of STLDI and reverse prior STLDI regulations issued under the Trump Administration, in an attempt to combat what proponents refer to as "junk insurance."

As background, STLDI is health insurance designed to fill temporary gaps in coverage when transitioning from one source of coverage to another. STLDI is exempt from the definition of "individual health insurance coverage" under the Public Health Service Act and is generally not subject to the applicable federal individual market consumer protections and requirements for comprehensive coverage under the Affordable Care Act ("ACA") (including, for example, the prohibition of preexisting condition exclusions).

Prior to 2016, federal regulation defined STLDI as health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions) that is less than 12 months after the original effective date of the contract. In 2016, the Obama Administration change the definition to provide that STLDI coverage must be less than three (3) months, including any renewal periods. In 2018, the Trump Administration further amended the definition of STLDI to expand its availability and duration to include coverage that does not exceed 36 months in total, including any renewal periods. This change resulted in a surge of STLDI plans for individuals seeking health coverage at a lower cost.

The proposed rule changes this definition again and aims to realign STLDI with its original purpose—to provide *temporary* coverage while transitioning from one coverage source to another (*e.g.*, transitioning between jobs or seeking coverage outside of open enrollment). Under the proposed rule, STLDI is limited to coverage with an initial contract period of no more than three (3) months and a maximum period of four (4) months (*i.e.*, three (3) months with a one-month renewal). Proponents of the change explain that the prior administration's expansion of STLDI allowed companies to sell, and individuals to remain on, STDLI, much longer than necessary, treating it as a primary health coverage option (but without the ACA protections and requirements that come with primary, comprehensive health coverage). The Biden administration contends that this change will prevent companies from taking advantage of this loophole and ultimately drive down health care costs as individuals will obtain more sufficient coverage sooner. The proposed rules also prohibit issuers from "stacking" or issuing multiple STLDI policies to a policyholder within a 12-month period. Notably, this change will apply to new STLDI plans only and existing plans will be grandfathered

and can continue to operate under existing rules, including the longer coverage periods mentioned above.

Employer plan sponsors will need consider how these changes might affect their benefit plans once the proposed rules become effective (which will be the later of the date the final rules are published or January 1, 2024). For example, it is possible that some employers may experience an increase in employees enrolling in employer-sponsored coverage due to the reduced availability and duration of STLDI plans pursuant to these changes.

Proposed Rules Include Significant Clarifications on Excepted Benefit Status and Taxation of Hospital, Accident, Critical Illness, Specified Disease and Other Fixed Indemnity Coverage

By Seth Capper

The Departments of Labor, Treasury, and Health and Human Services (the "Departments") recently published proposed regulations (available here) covering several issues affecting the health insurance industry. In addition to providing updated guidance regarding "short-term, limited-duration" insurance, discussed by my colleague, Claire Martin, in this issue of *Benefitting You*, the proposed regulations also included a number of significant changes and clarifications regarding the "excepted benefit" status and taxation of fixed indemnity insurance benefits, which include, for example, hospital, accident, critical illness, cancer, and other specified disease/illness coverage products (collectively, "Fixed Indemnity Plans").

Fixed Indemnity Plans as Excepted Benefits:

The Departments proposed a number of changes regarding when such Fixed Indemnity Plans can be considered "excepted benefits" for HIPAA portability/ACA purposes. As background, "excepted benefits" are group health plans that generally are not required to comply with HIPAA's portability and nondiscrimination requirements, which include, for example, many ACA and ERISA requirements. Under the proposed regulations, in order to be an excepted benefit, a Fixed Indemnity Plan would be required to pay benefits without regard to services or items received, actual or estimated expenses incurred, the severity of the illness or injury, or other characteristics particular to a course of treatment.

This proposed modification could require significant changes in benefit structures for Fixed Indemnity Plans offered by employers that do not meet ACA requirements (*e.g.*, prohibition on lifetime and annual dollar limits), particularly if the policy pays a fixed amount per service, which the Departments call out as being impermissible. Absent changes to the benefit structures themselves, employers could be required to integrate such Fixed Indemnity Plans with other ACA-compliant group health plan coverage in order to avoid a violation of the ACA rules.

Tax Treatment of Fixed Indemnity Plan Payments:

The proposed regulations also contain suggested changes to the Code § 105(b) regulations intended to provide clarification regarding the taxation of amounts received through employment-based Fixed Indemnity Plans (including addressing the substantiation requirements for the 105(b) tax exclusion, discussed below).

The proposed regulations would interpret Code § 105(b) as not applying to benefits paid without regard to the actual amount of incurred and otherwise unreimbursed medical expenses, meaning such payments made without regard to the actual amount of incurred and unreimbursed medical expenses would be includible in an employee's taxable compensation. The preamble states that "even if a benefit payment under [an] arrangement is used to reimburse an employee's medical expenses, if the amount of the payment is not tied to the amount of the expense incurred and the employee is entitled to keep any amounts by which the benefit payment exceeds the incurred expenses, that would indicate that the benefit is not actually a reimbursement for medical expenses."

As discussed above, to be an excepted benefit, the proposed regulations would require that a Fixed Indemnity Plan must pay benefits without regard to services or items received or actual or estimated medical expenses incurred. Accordingly, it appears that the Departments (and, specifically, the Treasury/IRS) are taking the position that the benefits paid under an excepted benefit Fixed Indemnity Plan—if the premiums for such plan were paid on a pre-tax basis—will not qualify for the 105(b) tax exclusion, even if the individual/plan substantiate the amount of medical expenses incurred related to the triggering event. This position is different from the IRS's position in previous Chief Counsel Advice (CCA) memoranda and represents a significant announcement as to how the IRS interprets the application of the 105(b) tax exclusion to reimbursements from Fixed Indemnity Plans.

Substantiation Requirements

Finally, with regard to substantiation of medical expenses under Fixed Indemnity Plans, the preamble quotes language from the current 105(b) regulations, which states that "[i]f amounts are paid to the taxpayer solely to reimburse him for expenses which he incurred for the prescribed medical care, section 105(b) is applicable even though such amounts are paid without proof of the amount of the actual expenses incurred by the taxpayer," and the preamble states that some have interpreted this language to suggest that substantiation of medical expenses is not required for the 105(b) exclusion to apply. The proposed regulations would clarify that, for amounts to be excluded from income under 105(b), the medical expenses for which payment or reimbursement is being sought under a Fixed Indemnity Plan must be substantiated. The preamble goes on to state that in cases where substantiation occurs after reimbursement, the IRS is of the view that such substantiation must occur within a reasonable period of time thereafter.

As noted above, under the proposed regulations, benefit payments under most Fixed Indemnity Plans would not qualify for the 105(b) tax exclusion, and thus, such payments would be includable in an employee's compensation to the extent the premiums for such policies are paid on a pre-tax basis (either because the premiums are paid by the employer or because they are paid by the employee on a pre-tax basis under a cafeteria plan. The substantiation rule does not appear to have an impact on those plans; however, for Fixed Indemnity Plans that only pay based on the actual amount of medical expenses incurred (and, thus, are not excepted benefits), this would require substantiation of the actual amount of medical expenses incurred in order for the 105(b) exclusion to apply.

Applicability of Proposed Regulations

The changes in the proposed regulations will only apply if and when final regulations are issued, likely with phased-in effective dates depending on when coverage renews. While no changes are currently required, employers that offer Fixed Indemnity Plans, particularly those that are entirely or partially employer-funded or for which employees are permitted to pay premiums on a pre-tax basis, should review those plans and be prepared to make changes if and when final regulations are published.

This Month's Compliance Corner: Best Practices for Summary Plan Descriptions (SPDs) and Summaries of Material Modifications (SMMs)

By Seth Capper

One crucial aspect of ERISA compliance is the requirement that plan administrators of employee benefit plans must provide summary plan descriptions ("SPDs") to all plan participants, as well as summaries of material modifications ("SMMs") whenever there are significant changes to plan terms. The SPD must describe individuals' rights, benefits, and responsibilities under the plan in easily understandable language, and it must meet a number of requirements in terms of the content that

must be included and how, when, and to whom it must be distributed. According to the Department of Labor ("DOL"), "the SPD is the primary vehicle for informing participants and beneficiaries about their rights and benefits under the employee benefit plans in which they participate."

What Plans are Subject to the SPD/SMM Requirement?

The SPD and SMM requirements apply to most ERISA "employee welfare benefit plans" ("ERISA Plans") with very few regulatory exceptions. ERISA Plans have three basic elements—there must be (1) a plan, fund or program; (2) that is established or maintained by an employer; (3) for the purpose of providing one or more of the following listed benefits to participants and beneficiaries: medical, surgical, or hospital care or benefits; benefits in the event of sickness, accident, disability, death or unemployment; vacation benefits; apprenticeship or other training programs; daycare centers; scholarship funds; prepaid legal services; holiday and severance benefits; or housing assistance benefits.

ERISA Plans include things like health (*i.e.*, major medical) plans, dental plans, vision plans, prescription drug plans, life and AD&D plans, long and short term disability plans, health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health "gap" or "bridge" plans (or other supplemental medical coverage), fixed indemnity coverage, employee assistance programs (EAPs), disease-management programs, telemedicine programs, on-site medical clinics, and prepaid legal plans. For any such benefits, employers must meet the SPD and SMM requirements, unless the plans fall under one of the few regulatory exemptions, the most significant of which is the exemption applicable to governmental and church plans.

To Whom Must SPDs/SMMs Be Provided?

Under DOL regulations, the plan administrator of a welfare benefit plan is required to furnish SPDs (and SMMs) only to *participants covered under the plan* and not to beneficiaries (note that the same is not true for retirement plans). The term "participant" is defined under ERISA as an employee or former employee of any employer who is or may become eligible for benefits under an ERISA Plan or whose beneficiaries are or may be eligible for benefits. Because the definition is not limited to current employees, it can include COBRA qualified beneficiaries, covered retirees, and other former employees who may remain eligible under a plan; however, the term participant does not specifically include a beneficiary.

A participant becomes "covered" under a plan on the earlier of (1) the date on which the plan provides that participation begins, (2) the date on which the individual becomes eligible to receive a benefit "subject only to the occurrence of the contingency for which the benefit is provided," or (3) the date on which the individual makes a plan contribution, whether voluntary or mandatory. Generally, SPDs need not be distributed to employees before they join a plan. If SPDs are furnished to eligible employees before they enroll in coverage, such SPDs should make clear that enrollment (and payment of premiums) is a condition of receiving benefits under the plan.

When Must SPDs/SMMs Be Provided?

<u>SPD Distribution Timing:</u>

Generally, an SPD must be furnished when a participant first becomes covered by a plan and then at regular intervals thereafter. For a participant who is newly covered under an existing plan, an SPD must be furnished within 90 days after the participant first becomes covered under the plan (along with any SMMs previously furnished to participants, the content of which has not yet been incorporated into the SPD). For new plans, an SPD must be furnished to covered participants (and others so entitled) within 120 days after the plan first becomes subject to ERISA.

An updated SPD must be furnished at least every five years if there have been any material changes made within that five-year period. If no such material changes were made during the immediately preceding ten-year period, then a copy of the most

recently distributed SPD must be re-furnished by the plan administrator at least once every ten years.

SMM Distribution Timing:

An SMM is required anytime there is a "material modification" in the terms of the plan or any change in the information required to be in the SPD. Whether a modification or reduction is considered to be "material" generally is a facts-and-circumstances determination; however, plan administrators should consider erring in favor of furnishing SMMs whenever plan changes are made. Among other things, changes in any of the information required to be included in the SPD will require an SMM, and adoption of new legislation or regulations may require an SMM. It is important to note that plan administrators need not furnish an SMM if the modifications in question are, instead, incorporated into an updated SPD, which is distributed by the applicable SMM deadline.

As a general rule, the plan administrator must furnish an SMM within 210 days after the end of the plan year in which a modification is adopted. However, any modification to a *group health plan* that is considered a "material reduction in covered services or benefits provided under the plan," must be disclosed no later than 60 days after the date of adoption of the change. As with material modifications in general, the determination of whether a change results in a "material reduction" with respect to a group health plan is based on the facts and circumstances. Generally speaking, however, any modification that, independently or in conjunction with other contemporaneous modifications, would be considered by the average plan participant to be an important reduction in covered services or benefits constitutes a "material reduction."

SPDs and SMMs must also be furnished to a participant or beneficiary within 30 days after his or her written request. Failure to do so may result in penalties under ERISA § 502(c)(1) of up to $110 per day.

How Must SPDs/SMMs be Distributed?

SPDs and SMMs must be furnished in a way "reasonably calculated to ensure actual receipt of the material." Probably the two most common methods of distributing SPDs (and SMMs) are by first-class mail or through electronic delivery. DOL regulations provide several examples of acceptable SPD distribution methods, including first-class mail (and second- or third-class mail, if return and forwarding postage is guaranteed and address correction is requested). DOL regulations also expressly provide that SPDs and SMMs may be furnished electronically (including, for example, through email or intranet postings, if certain specific requirements are met). Note that the electronic disclosure rules are complicated and are beyond the scope of this article. Employers that utilize electronic methods for delivering SPDs, SMMs, and other required documents to plan participants, or those that wish to do so, are encouraged to reach out to their consultants/advisors for guidance as needed.

What Information Must be Included in an SPD?

SPDs must include certain basic plan-identifying information, as enumerated in DOL Regulation § 2520.102-3. The DOL regulations also require that SPDs include a statement of the eligibility requirements for participation and any conditions that must be met in order to receive benefits. Satisfying this SPD content requirement in most cases will require describing not only employee eligibility requirements but also enrollment and open enrollment requirements, special enrollment, and eligibility for spouses, domestic partners, and children.

DOL regulations also require that SPDs include: (1) a description of the benefits the plan provides; (2) a statement clearly identifying circumstances that may result in disqualification and ineligibility, and in denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits that a participant or beneficiary may reasonably expect the plan to provide; (3) relatively detailed descriptions regarding plan amendment and termination authority/rights; (4) provisions regarding a plan's subrogation and reimbursement rights; (5) disclosures regarding the sources of contributions to the plan (*e.g.*, employer

contributions, employee contributions, or both), the method by which the amount of contributions are calculated (and information about other plan costs, if any), and the plan's funding method; (6) detailed benefits claims and appeals procedures; and (7) a statement describing the ERISA rights of participants and beneficiaries.

Additional SPD content requirements apply to ERISA Plans that are group health plans. DOL regulations require a more detailed description of the benefit provisions of a group health plan, as laid out in DOL Regulation § 2520.102-3(j)(3). ERISA and DOL regulations require group health plan SPDs to describe certain information when a "health insurance issuer" is responsible in whole or in part for the financing or administration of a group health plan. In such a case, the SPD must include (a) the name and address of the health issuer; (b) whether, and to what extent, benefits under the plan are guaranteed under a contract or policy of insurance issued by the health issuer; and (c) the nature of any administrative services (e.g., claims processing and payment) provided by the health issuer.

In addition to the description of plan claims procedures required in the SPDs of all welfare plans, the SPD of a group health plan must provide information regarding procedures for obtaining pre-authorizations, approvals, or utilization review decisions. A group health plan SPD must also disclose the "office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under [HIPAA] with respect to health benefits that are offered through a group health plan." Finally, a group health plan must include specific disclosures required under COBRA, HIPAA, the ACA, and other applicable federal laws.

Using "Wrap" Plans to Meet SPD Requirements

Although an employer as plan administrator is legally responsible for SPDs, insurers often provide descriptive documents intended for distribution to eligible individuals. Such documents may even be called summary plan descriptions. However, these documents often do not contain all of the required elements for an SPD in general, and they may not include certain information that needs to be reflected in the SPD (*e.g.*, multiple locations, controlled group issues, accurate plan number(s)). On the other hand, the description of benefits contained in such documents is typically very thorough. Therefore, one recommended approach is to supplement the insurers' benefits documents with a "wrap plan" SPD (which also, among other things, permits an employer to file a single annual Form 5500 for all ERISA Plans the employer sponsors, rather than having to file separate 5500s for each benefit).

As the name implies, the wrap plan SPD "wraps" around the insurer-provided documents, and together, the two documents satisfy the SPD requirements. In other words, the wrap plan SPD includes required SPD content that the insurers' documents do not include, and the insurers' documents typically include detailed benefits descriptions that a wrap plan SPD would not include. Employers that do not currently have wrap plan SPD documents in place are encouraged to reach out to their advisors and/or legal counsel for assistance.

2023 Fixed Deadline Reminders		
Annual Medicare Part D Notice of Creditable (or Non-Creditable) Coverage to Eligible Individuals		October 14, 2023
Health Plans Must Submit Gag Clause Attestations **Submitting attestations requires registration through the CMS HIOS system. Contact your benefits consultant regarding this process. MaynardNexsen is registered and able to submit attestations on behalf of clients, if needed.*		December 31, 2023
2024 Fixed Deadline Reminders		
ACA Reporting for Applicable Large Employers	**Forms 1095-C to Full-Time Employees**	March 1, 2024
	Forms 1094-C and 1095-C to IRS	March 31, 2024
HIPAA Breach Disclosure to HHS		March 1, 2024
Annual Form M-1 for MEWAs		March 1, 2024
Two-Year Reporting of Air Ambulance Services Data to DOL, IRS, HHS		March 30, 2024 (2023 Data)
Reporting on Prescription Drug Costs		June 1, 2024 (2023 Data)
PCORI Fee		July 31, 2024
Annual Medicare Part D Notice of Creditable (or Non-Creditable) Coverage to Eligible Individuals		October 14, 2024
Health Plans Must Submit Gag Clause Attestations		December 31, 2024

STAY IN THE KNOW...

For plan years beginning in 2024, the maximum amount that may be made newly available for the plan year for an excepted benefit health reimbursement account ("HRA") is $2,100.

On July 31, 2023, the U.S. Department of Labor ("DOL") filed suit against third-party claims administrator, UMR, Inc., a subsidiary of UnitedHealth Group Inc. of Minneapolis, alleging that UMR improperly denied participant claims for emergency room visits, where UMR's procedures relied solely on diagnosis codes and did not comply with the "prudent layperson" standard under applicable law. DOL also found that UMR denied nearly all urinary drug screening claims without reviewing the claims for medical necessity. The lawsuit seeks to hold UMR accountable for breaching its fiduciary duty to plan participants among other claims.

On July 26, 2023, the U.S. Equal Employment Opportunity Commission issued new guidance to employers on how the Americans with Disabilities Act applies to job applicants and employees with vision impairments. The guidance provides frequently asked questions about how employers should assess accommodation requests from individuals with vision impairments and reminds employers that whether a vision impairment constitutes a direct threat or safety risk on the job is determined based on an individualized assessment, unique to the individual, the particular job, and the circumstances of the work environment.

**While some deadlines are the same date for all plans ("fixed deadlines"), many important deadlines are different for each plan depending on, for example, when the plan year ends.*

This Month's Contributors

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Kate joined the firm in 2022 after graduating magna cum laude from Cumberland School of Law. Her is largely focused on the design, implementation, and maintenance of 401(k), profit sharing, defined benefit/pension (including cash balance), employee stock ownership and welfare plans, as well as executive and deferred compensation programs.