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GENERAL DEVELOPMENTS

**Please note, this article was published prior to President Biden's inauguration. Shortly thereafter, the President executed an order placing a hold on certain regulations and proposals pending further review. Updates marked below are subject to the President's order and have not been published. We will keep you updated on their status as more information becomes available.*

The Consolidated Appropriations Act of 2021 Impact on Employer-Sponsored Health and Retirement Plans

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act of 2021 (CAA). The CAA represents the federal government's latest attempt to provide relief from the ongoing COVID 19 pandemic and it includes numerous provisions affecting both health and welfare as well as qualified retirement plans. Additional details on the health and welfare plan provisions and the qualified retirement plan provisions are available in the preceding links, but generally, the CAA impacts employers and plan sponsors as follows:

Health and Welfare

- Flexible Spending Account Measures. The CAA increases employers' flexibility with regard to health flexible spending accounts (FSAs) and dependent care FSAs. Employers may: (1) amend their plans to loosen carryover restrictions for plan years ending in 2021 and 2022; or (2) adopt extended grace periods allowing participants to spend unused amounts and contributions for up to 12 months following the end of the 2020 and 2021 plan years. Employers can also allow employees to prospectively change the amount of their FSA elections without changing their status.
- No Surprises Act. The CAA includes a number of provisions to eliminate surprise medical billing. Aptly named the "No Surprises Act," the changes go into effect for plan years beginning in 2022. The No Surprises Act requires both non-grandfathered and grandfathered plans to cover emergency services without prior authorization at both in and out of network providers. Plans and insurers must also implement billing procedures that treat out-of-network providers who operate at network facilities the same as their in-network counterparts. Finally, the No Surprises Act creates an independent dispute

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resolution process that plans, insurers, facilities and providers may use to determine the appropriate billing rate for out of network services.

- Continuity of Care. Plans and insurers are required to notify "continuing care patients" of provider contract changes that result in a loss of benefits. Certain participants must be allowed to continue their benefits as if the change had not occurred for a transition period of 90 days following the notice.
- Increased Transparency for Participants. As part of the No Surprises Act, plans must provide participants with increased access to information regarding the plan and its coverage. Among those provisions, for plan years beginning in 2022, plans and insurers must identify participants' deductible or out-of-pocket maximum on any issued identification cards. Plans must also provide an advance cost estimate to covered individuals that details the cost information and coverage status of a scheduled procedure. To further increase transparency, plans must establish an online directory of network providers and must timely respond to participant requests for network information.
- Grandfathered Plans. For plan years beginning in 2022, grandfathered plans under the Affordable Care Act (ACA) will be subject to the ACA's patient protections. Accordingly, all persons in plans that require designation of a primary care provider may select any available participating provider, including a pediatrician in the case of a child, and have direct access to obstetrical or gynecological care without a referral.
- Compensation Disclosure for Brokers and Consultants. The CAA requires brokers, consultants and service providers to specify their direct and indirect compensation to satisfy the "reasonableness" requirement of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Covered service providers must notify the plan of any indirect compensation before the date their contract is entered into, extended or renewed. The CAA also establishes a procedure through which plan fiduciaries and service providers can correct an insufficient disclosure before the arrangement is considered a prohibited transaction under ERISA.
- Removing Gag Clauses on Price and Quality Information. The CAA prohibits group health plans from entering into contracts with health providers, third-party administrators or other service providers that would restrict the plan from providing provider-specific cost or quality of care information to relevant parties including, for example, the plan sponsor and other covered individuals. Furthermore, plans cannot enter into contracts that prohibit the plan from accessing de-identified claims and encounter information for a participant on request and in a manner consistent with applicable federal law. Finally, plans must provide an annual attestation that they are in compliance with the above

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requirements.

- Mental Health and Substance Abuse Services Guidance. Plans and insurers must perform formal comparative analyses of their non-quantitative treatment limitations (NQTLs) within 45 days of the CAA's enactment (February 10, 2021) to satisfy the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). After that deadline, plans must make their findings available upon request to the Secretaries of Labor or Health and Human Services, or the applicable state authority. If a plan is found noncompliant, it must take remedial action within 45 days, or else be required to notify all enrollees of the adverse determination. The Departments of Labor, Health and Human Services, and the Treasury will create a compliance program to help plans fulfill their obligations under the MHPAEA and update it on a biannual basis.

Retirement Plans

- Disaster Provisions. The CAA includes three types of relief for individuals affected by recent "qualified disasters": (1) the option to take a "qualified disaster distribution" of up to $100,000; (2) the ability to repay hardship distributions intended for the building or purchasing of a home in a qualified disaster area; and (3) temporary modifications to plan loan rules that allow affected individuals to delay repayment of existing plan loans and to receive new loans of up to $100,000 or 100 percent of the vested portion of their account. A "qualified disaster" is an event declared a disaster by the President between January 1, 2020 and February 25, 2021. Plan sponsors may amend their plans to adopt these relief provisions until the last day of the plan year that begins on or after January 1, 2022.
- Relief from Partial Plan Termination Rules. The CAA provides plans with temporary relief from partial plan termination rules if they meet certain requirements. Under the CAA, plans will not be required to provide immediate 100 percent vesting of benefits if the number of active participants covered by the plan on March 31, 2021, is at least 80 percent of the active participants covered by the plan on March 13, 2020.
- In-Service Distributions for Building Trade Employees. The CAA lowers the age at which building and construction industry employees who participate in certain multiemployer retirement plans can receive in-service distributions, from age 59 1/2 to age 55. An employee is eligible if he or she became a participant in the plan on or before April 30, 2013. For a plan to be eligible, it must: (1) be a multiemployer plan covering participants in the building and construction industry; (2) have a trust that was in existence prior to January 1, 1970; and (3) have received at least one written determination letter from the

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Internal Revenue Service (IRS) prior to December 31, 2011 stating that the plan was qualified.

- Qualified Future Transfer Relief. Under Internal Revenue Code (IRC) section 420(f), plan sponsors can shift funds from an overfunded pension plan to fund a retiree health plan account and/or a retiree life insurance account through a "qualified future transfer." The new relief allows employers to elect to end the transfer period for any qualified future transfer prior to December 31, 2021. That election may be effective for any taxable year that begins after the date of election.
- Money Purchase Plan Coronavirus Related Distributions. The CAA amends the Coronavirus Aid, Relief, and Economic Security (CARES) Act to allow sponsors of money purchase pension plans to permit eligible individuals to take coronavirus related distributions (CRDs). However, the CARES Act deadline for plans to distribute CRDs was December 31, 2020.

RETIREMENT PLAN DEVELOPMENTS

New Proxy Voting Rules for ERISA Fiduciaries*

As reported in the September 2020 Benefits Counselor, in August 2020, the U.S. Department of Labor (DOL) issued a proposed rule addressing proxy voting rules and responsibilities for plan fiduciaries under ERISA. On December 11, 2020, the DOL released the final version of the rule, titled "Fiduciary Duties Regarding Proxy Voting and Shareholder Rights." Although the final rule is largely similar to the proposed rule, the DOL has moved toward a principles-based design that should lessen the burden of the new rule on plan fiduciaries.

Unlike the proposed rule, the final rule clarifies that fiduciaries *are not required* to vote every proxy or exercise every shareholder right. However, in those instances where a fiduciary does vote a proxy or exercise a shareholder right, the final rule identifies six principles that the fiduciary must follow:

- Acting solely in accordance with the economic interest of the plan and its participants and beneficiaries, without considering merely "theoretical" benefits;
- Considering costs involved in voting or taking action;
- Avoiding any action that would subordinate participants' financial interests to non pecuniary objectives, or promote non pecuniary objectives or goals unrelated to the financial interests of participants and beneficiaries;
- Evaluating material facts forming the basis of the proxy vote or other exercise of shareholder rights;

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- Maintaining records of proxy voting and shareholder rights decisions; and
- Exercising prudence and diligence in selecting and monitoring of persons chosen to advise or assist with the exercise of shareholder rights.

The final rule also establishes two safe harbors that would allow fiduciaries to satisfy their responsibilities regarding voting proxies or exercising shareholder rights:

- A policy that limits voting to only particular types of proposals that are substantially related to the corporation's business activities or are expected to have a material effect on the value of the investment; and
- A policy of refraining from voting on proposals or types of proposals when the fiduciary prudently determines that the plan's holdings in the stock are sufficiently small that the matter being voted upon is not expected to have a material effect on the investment performance of the plan's portfolio.

The final rule becomes effective on January 15, 2021. However, the DOL has set a later effective date of January 31, 2022, for fiduciaries to comply with several provisions, including: (1) evaluating material facts forming the basis of a proxy vote; (2) maintaining records of proxy voting and shareholder rights decisions; and (3) exercising prudence and diligence in selecting and monitoring persons authorized to exercise shareholder rights.

IRS Notice 2020-86 Provides SECURE Act Guidance for Safe Harbor 401(k) Plans

The IRS issued Notice 2020 86 to provide additional guidance to plan sponsors of safe harbor plans following the enactment of the Setting Every Community Up for Retirement Enhancement (SECURE) Act earlier this year. More specifically, the Notice addresses issues related to maximum deferral percentages in Qualified Automatic Contribution Arrangement (QACA) safe harbor plans, general safe harbor notice requirements and the retroactive adoption of safe harbor status for certain plans.

Looking first at QACA safe harbor plans, the Notice clarifies that plan sponsors are not required to increase the maximum automatic deferral percentage from 10 percent to 15 percent, as authorized by the SECURE Act. That option also applies to QACA safe harbor plans that incorporate the maximum percentage by reference in their plan documents. Those plans wishing to maintain the 10 percent maximum percentage must amend their documents by the end of 2022. Failure to do so will result in retroactive application of the 15 percent maximum to the first day of the plan year beginning after December 31, 2019.

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Next, the Notice clarifies section 103 of the SECURE Act, which eliminates safe harbor notices for plans that provide nonelective contributions, by providing that participant notice requirements are eliminated for matching contribution QACA safe harbor plans that feature nonelective contributions. However, plans that use traditional safe harbor matching contributions are not included in section 103 of the SECURE Act and must still provide notice. The same goes for eligible automatic contribution arrangements that feature nonelective contributions.

Finally, the Notice provides guidance for safe harbor plans that want to retain the right to reduce or suspend nonelective contributions. These plans must provide notice to participants and satisfy applicable Treasury regulations. If a plan reinstates nonelective contributions after reducing or suspending benefits, it must amend its plan documents no later than 30 days prior to the end of the plan year to avoid Actual Deferral Percentage (ADP) or Actual Contribution Percentage (ACP) testing.

IRS Publishes Final Regulations for Plan Loan Offset Rollovers

On December 7, 2020, the IRS released final regulations related to the extended rollover period for qualified plan loan offsets (QPLOs), as created by the Tax Cuts and Jobs Act of 2017. The final regulations are nearly identical to the proposed regulations issued in August. Under the regulations, a QPLO is a loan offset distributed from a qualified employer plan solely because the employer terminates the qualified employer plan; or the employee terminates employment, provided the offset occurs within one year following termination of employment. Unlike the proposed regulations, the IRS delayed the effective date of the regulation to apply to QPLOs that are distributed on or after January 1, 2021.

IRS Extends Relief for Remote Notarization

On December 22, 2020, the IRS extended its temporary guidance that removes the requirement for participant elections to be witnessed *in the physical presence* of a plan representative or notary public. Under the IRS extension, issued in Notice 2021 03, participants can use remote notarization systems that meet certain requirements in place of in person notarization from January 1, 2021 through June 30, 2021. Furthermore, the Notice also includes a request for public comment regarding whether the remote notarization rules should be made permanent and whether any additional safeguards are needed.

HEALTH AND WELFARE PLAN DEVELOPMENTS

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Supreme Court Upholds State Regulations on PBM Reimbursements to Pharmacies

In *Rutledge v. Pharmaceutical Care Management Association*, the U.S. Supreme Court unanimously upheld an Arkansas law regulating pharmacy benefit managers (PBMs). Generally, PBMs contract with group health plans to serve as middlemen between the plan and pharmacies. Because of their significant bargaining power, PBMs can often set the rate at which pharmacies are reimbursed for prescription drugs. In response to widespread issues with these rates, Arkansas enacted a law requiring PBMs to reimburse pharmacies at a rate equal to or greater than what the pharmacy paid to acquire the drug.

Shortly thereafter, opponents of the regulation filed suit and claimed that the regulation was preempted by ERISA because it "related to" or had an "impermissible connection to" ERISA plans. The Supreme Court disagreed. In its decision, the Supreme Court found that the law is not preempted because it does not force plans to change their administrative practices. In short, the law is simply a form of cost regulation with a secondary effect of requiring plans to pay more for prescription drugs in Arkansas.

Overall, this ruling allows states to enact regulations that indirectly impact group health plans by raising costs. Further litigation may be necessary to determine when a state goes too far, increasing costs to such an extent that plans must change their administrative practices.

HHS Issues Proposed Rule Changing the HIPAA Privacy Rule*

On December 10, 2020, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) released a proposed rule that substantially alters the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. The proposed rule is the culmination of the HHS's Regulatory Sprint to Coordinated Care, an administrative effort to decrease regulatory impediments to care coordination and case management communications. For a more detailed discussion on the proposed rule, please be on the lookout for our upcoming news alert, but generally, the proposed rule would modify the Privacy Rule as follows:

- Increasing individuals' right to access their protected health information (PHI), *g.*, including in person access, individuals' ability to take notes or photos of PHI, and standardizing the timing, form and format for covered entities to respond to individual requests.
- Requiring health plans to respond to records requests from other covered entities when directed by individuals pursuant to the right of access.

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- Requiring covered entities to post information on their websites regarding PHI request fees.
- Clarifying the scope of covered entities' abilities to disclose PHI to third parties, such as social services agencies, to facilitate coordination and case management.
- Relieving covered entities of the minimum necessary requirement for uses by, disclosures to, or requests by a health plan or covered health care provider for care coordination and case management activities with respect to an individual, regardless of whether those activities constitute treatment or health care operations.
- Eliminating the requirement to obtain an individual's written confirmation of receipt of a Notice of Privacy Practices. The rule further requires entities to slightly update their Notice of Privacy Practices to reflect additional guidance.

Public comments on the proposed rule will be due 60 days after its publication in the *Federal Register*.

Final Rule Helps Plans Maintain Grandfathered Status*

In our August 2020 Benefits Counselor, we discussed a proposed rule issued by the Departments of Labor, Treasury, and HHS (the Departments) that will make it easier for grandfathered health plans to keep that status under the ACA. After receiving public comments, on December 15, 2020, the Departments published a final rule that falls in line with the earlier proposal.

Under the final rule, grandfathered plans featuring a high deductible health plan can adjust their fixed amount cost sharing requirements to comply with the minimum deductible and maximum out of pocket limits set by the Treasury Department.

Furthermore, the final rule allows grandfathered plans to calculate the "maximum percentage increase" for fixed amount cost sharing requirements using a new formula. The new formula states that maximum percentage increase may be the portion of the premium adjustment percentage that reflects the relative change between 2013 and the calendar year before the effective date of the increase (that is, the premium adjustment percentage minus one), expressed as a percentage, plus 15 percentage points.

This new formula should allow plans to make larger changes to their cost sharing requirements while maintaining compliance with the ACA.

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OCR Audit Finds Widespread HIPAA Compliance Failures

On December 17, 2020, the OCR released its 2016 2017 HIPAA Audits Industry Report that summarizes the findings of more than 200 compliance audits of health care entities and business associates. Starting with the good news, the OCR found that most covered entities provided breach notifications to individuals in a timely manner and prominently posted their Notice of Privacy Practices on their websites. Unfortunately the good news ends there. In the report, the OCR noted that most covered entities failed to adequately safeguard PHI, failed to ensure individuals' right of access and failed to include the appropriate content in their Notice of Privacy Practices. Even further, the OCR found that less than 20 percent of covered entities and business associates adequately performed their risk analysis and risk management responsibilities under the HIPAA Security Rule. Overall, the OCR concluded that covered entities and business associates should update their policies, procedures and technology to ensure future compliance with HIPAA's strict requirements.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Health Plan Compliance Deadlines and Reminders

HIPAA Breach Reporting: Plans must file their annual breach reports with the OCR by March 1, 2021. The annual breach report is for breaches involving fewer than 500 individuals that occurred during the preceding year. Breaches involving 500 or more individuals must be reported no later than 60 calendar days from the date of the breach's discovery.

ACA Reporting Information

Furnish Forms 1095-B and 1095-C to Participants: Subject to limited exception, plan sponsors of self funded health plans and Applicable Large Employers (ALEs) must distribute Forms 1095 B and 1095 C to participants by March 2, 2021.

File Forms with IRS: Plan sponsors and ALEs must file the transmittal Forms 1094 B and 1094 C with their corresponding Forms 1095 with the IRS by March 1, 2021 (March 31, 2021 if e filing).

Retirement Plan Compliance Deadlines and Reminders

Form 1099 R: Plan sponsors must file the Form 1099-R with the IRS by March 1, 2021 (March 31, 2021 if e filing).

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