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RETIREMENT PLAN DEVELOPMENTS

PBGC and IRS Issue Guidance Detailing Multiemployer Plan Assistance

On July 9, the Pension Benefit Guaranty Corporation (PBGC) issued interim final rules implementing a new Special Financial Assistance (SFA) Program for financially troubled multiemployer pension plans. The interim final rules implement provisions of the American Rescue Plan Act that provides approximately $94 billion in assistance to eligible plans that are severely underfunded. The PBGC intends for the SFA Program to provide eligible multiemployer plans with financial assistance in the amounts required to pay all benefits due during the period beginning on the date of payment of the assistance through the plan year ending in 2051.

The interim final rules address a variety of issues, including:

- Requirements for SFA applications;
- Information plans are required to file to demonstrate SFA eligibility;
- Formulae for determining the amount of SFA that the PBGC will pay to an eligible plan;
- Establishing the priority order in which plans may apply for SFA;
- Outlining the processing system that will accommodate the filing and review of SFA applications;
- Specifying permissible investments for SFA funds; and
- Establishing restrictions and conditions on plans that receive SFA.

The PBGC will accept comments to the proposed rules for 30 days following publication in the Federal Register.

On the same day, the Internal Revenue Service (IRS) also issued guidance to multiemployer plans that will receive SFA assistance from the PBGC under the new SFA Program. The IRS guidance provides clarification regarding:

- How plans must reinstate previously suspended pension benefits, along with

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make-up payments, as a condition to receipt of SFA Program assistance;

- The individual tax treatment of such make-up payments; and
- How plans must treat SFA Program assistance for purposes of minimum funding requirements.

IRS Extends Relief from Physical Presence Requirement for Witnessing Electronic Signatures

The IRS has announced that its temporary relief from the requirement that certain signatures be physically witnessed in the presence of a plan representative or notary has been extended by 12 months. The IRS originally provided relief from the physical presence requirement for any signature requiring the physical presence or witness or a plan representative or notary, including spousal consent requirements. Under the guidance, signatures witnessed by a notary public satisfy the physical presence requirement if the electronic system for remote notarization uses live audio-video technology consistent with state law requirements. Signatures requiring the physical presence of a plan representative are deemed satisfactory if the electronic system uses live audio-video technology, contains live presentation of the individual's photo ID, direct interaction, same-day transmission and return with the representative's acknowledgement.

In IRS Notice 2021-40, the IRS extended the temporary relief period through June 30, 2022. The notice also requests comments regarding whether the IRS should permanently modify the physical presence requirement, particularly regarding costs and other effects of the physical presence requirement and the temporary waiver, whether the waiver has resulted in fraud, coercion, or other abuses and what procedural safeguards should be instituted if the physical presence requirement is permanently modified. Comments are requested by September 30, 2021.

IRS Finalizes Regulations Regarding Minimum Deadline Extensions after Federally Declared Disasters

The IRS issued final regulations clarifying the mandatory 60-day extension of certain time-sensitive tax-related deadlines after a "federally declared disaster." Under the Further Consolidated Appropriations Act of 2020, the Secretary of the Treasury is permitted to authorize deadline extensions for qualified taxpayers beginning on the earliest incident date of a qualifying disaster and ending 60 days from the latest incident date for the disaster. The legislation also added 60-day

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minimum extension periods for retirement plans, sponsors, administrators, participants and beneficiaries to make contributions and rollovers, as well as certain contribution recharacterizations.

The final regulations clarify several items in the legislation, including:

- Disaster extensions are not automatic and the Secretary must determine which, if any, deadlines will be extended. If no time-sensitive items are postponed resulting from a qualifying disaster, the Secretary is not required to provide any extensions.
- The 60-day mandatory extensions will generally run concurrently with any discretionary relief period authorized by the IRS in connection with the beginning incident date of a disaster. If the discretionary relief period runs out, the extension will continue to run until 60 days after the latest specified incident date. If a qualifying disaster has no specified incident date (e.g., COVID-19), the 60-day mandatory extension will not apply.
- Disasters that can trigger the 60-day mandatory extension include both major disasters and emergencies declared under the Stafford Act.

The regulations clarifying the definition of a qualifying disaster are applicable on June 11, 2021. The remainder of the regulations are applicable for disasters declared on or after December 21, 2019.

HEALTH AND WELFARE PLAN DEVELOPMENTS

DOL, HHS and IRS Issue Guidance Regarding Surprise Medical Billing Requirements

The U.S. Department of Labor (DOL), Department of Health and Human Services (HHS) and the IRS have released regulations regarding surprise medical billing requirements under the No Surprises Act (the Act), enacted in December 2020 under the Consolidated Appropriations Act of 2021. The Act contains provisions intended to protect individuals from surprise medical bills issued for emergency services from out-of-network or non-participating providers or facilities and non-emergency services from non-participating providers at in-network facilities.

The new regulations generally limit cost-sharing for out-of-network services covered under the surprise billing protections to in-network levels and requires such expenses be included toward in-network deductible and out-of-pocket maximums. The regulations also establish requirements for initial payments to

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out-of-network and non-participating providers, as well as prohibit surprise balance billing. Other highlights include:

- The regulations reiterate that the Act applies to both grandfathered and non-grandfathered group health plans under the Affordable Care Act (ACA). However, the guidance does not apply to standalone health reimbursement arrangements, excepted benefits, short-term insurance or retiree-only plans.
- The regulations provide that group health plan participants will be responsible for paying cost-sharing for items and services identified by the Act based on such items or services "recognized amount," which will generally be the lesser of the plan's median in-network rate (i.e., the "qualifying payment amount") and the amount billed by the provider, subject to applicable state law.
- The regulations also promulgate rules for determining the out-of-network rate payable by a plan or insurer for items and services within the scope of the Act. Plans generally must pay an initial amount or issue a notice of denial to a non-participating or out-of-network provider within 30 days of receipt of all information necessary to determine a claim for the item or service. The regulations clarify that the plan or insurer's initial payment refers to the entire amount the plan or insurer reasonably intends to pay in full to the provider, rather than a first installment.
- Once the plan has determined the recognized amount for such items and services, the plan must provide notice to the non-participating or out-of-network provider. Such notice must identify the plan's contact person if the provider wishes to initiate negotiations regarding the plan's total payment and identify the deadline to initiate independent dispute resolution if an agreement cannot be reached. The agencies note that they expect to issue further guidance with respect to the independent dispute resolution process at a future date.
- The Act generally exempts non-emergency services furnished by a non-participating provider at a participating health care facility from balance billing and cost-sharing protections if the provider complies with the Act's advance notice requirements and obtains patient consent. The regulations clarify that such non-participating providers (or the facility, if applicable) must also provide timely notice to the plan or insurer to allow for the correct calculation of cost-sharing and provide signed copies of any binding notice and consent documents to take advantage of such exemption.

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- The regulations provide a model notice for plans and insurers to post and include in any explanation of benefits to which the Act applies. Beginning in 2022, plans and insurers that provide the notice shall be deemed to have complied in good faith with the Act's requirement that such parties disclose prohibitions on surprise billings and appropriate entities to contact in the event of a violation.

The regulations are generally effective for plan and policy years beginning on or after January 1, 2022.

HHS Proposes Various Amendments to Benefit and Payment Parameters for 2022

HHS has proposed regulations to amend and repeal various benefit and payment parameters under the ACA. Highlights include:

- Beginning in 2022, HHS has proposed to lengthen the annual open enrollment period for federal and state-offered exchange plans to November 1 through January 15 (currently, annual open enrollment is from November 1 through December 15). The extended open enrollment period also applies to non-grandfathered plans in the individual market outside the exchanges. The proposed regulations also establish a new monthly special enrollment period on the federal exchange for individuals eligible for advance payment of the premium tax credit whose household income does not exceed 150 percent of the federal poverty level.
- The proposed rules would repeal the exchange direct enrollment option, which provides for exchanges to work directly with insurers, agents and brokers to operate enrollment websites.
- The proposed rules include a technical amendment to ACA essential health benefit requirements that clarifies that health plans required to cover essential health benefits must also comply with the requirements of the Mental Health Parity and Addiction Equity Act.

Supreme Court Rejects Attempt to Invalidate Affordable Care Act

The U.S. Supreme Court has rejected another attempt to invalidate the ACA, holding that challengers lacked standing to bring their case. Two individuals and 18 states argued that the elimination of the individual mandate penalty in 2019 invalidated the law, as the requirement that individuals maintain minimum essential health coverage could no longer be categorized under Congress's taxing

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power.

The Court held that the plaintiffs lacked standing because they failed to show they suffered an injury attributable to the challenged provision. With respect to the individual plaintiffs, the Court noted that because neither the IRS nor any other federal agency could penalize individuals that failed to purchase minimum essential coverage, the individual's alleged injury (i.e., the cost of purchasing health insurance) could not be tied to the elimination of the individual mandate. The Court also found that the states failed to demonstrate that increased use and expenses of state-operated medical insurance programs (*e.g.*, Medicaid) and increased administrative expenses were traceable to the repealed individual mandate.

GENERAL DEVELOPMENTS

IRS Announces Tax Relief Extension for Leave-Based Donations to Victims of COVID-19 Pandemic

In Notice 2021-42, the IRS announced a one-year extension of tax relief for leave-based donation programs established to aid victims of the COVID-19 pandemic. Employers may generally permit their employees to give up vacation, sick or personal leave in exchange for cash payments by the employer to a charitable organization under a leave-based donation program. Although such donations ordinarily must be included in the donating employee's income, the IRS provided relief that such donations made by employers to organizations for the relief of COVID-19 in 2020 would not be treated as wages, compensation or otherwise included in employee income. The IRS has extended this relief to donations made to qualified tax-exempt organizations through the end of 2021.

DOL Issues Information Letter Rejecting Plan's Refusal to Provide Recording and Transcript of Claim Conversations

The DOL has issued an information letter rejecting attempts by a plan to provide a claimant with an audio recording and transcript of a telephone conversation regarding the claim. Generally, the DOL's claims procedure regulations require that, upon request and free of charge, claimants be given copies of all documents, records and other information relevant to the claim. In this case, a claimant was denied access to a recording of a conversation that took place between the claimant and a plan's representative. The plan alleged that it did not need to provide the recording as it was created merely for "quality assurance purposes," rather than for purposes of claims administration. The plan also provided contemporaneous notes documenting the conversation that were part of the

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record used for tracking and administering the claim to the claimant.

The DOL noted that such recordings are “relevant” to a claim if it was generated in the course of making a claim determination, regardless of whether such material is actually relied on in making the determination. Furthermore, the DOL stated that the fact the recording was made for quality assurance purposes tended to support its relevance, given that the regulations provide that information is relevant if it demonstrates compliance with the claims procedures. Finally, the DOL emphasized that the regulations do not restrict the disclosure requirement to paper or written materials.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

2020 Form 5500 for Calendar Year Plans**.** Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2020, the Form 5500 filing deadline is July 31, 2021. However, by filing Form 5558 by July 31, 2021, plan administrators can request a deadline extension to October 15, 2021.

Summary Annual Report**.** Plan administrators whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year end (e.g., for plan years that ended December 31, 2020, the deadline is September 30, 2021). However, if a plan has received an extension for filing its Form 5500, the nine-month deadline is extended by two months.

SMM for Calendar Year Plans**.** Plan administrators generally have 210 days after the end of a plan year to provide a Summary of Material Modifications (SMM) of a plan change. Thus, for a plan change adopted in 2020, the deadline to provide the SMM to participants is July 30, 2021.

Health Plan Compliance Deadlines and Reminders

PCORI Fee. Plan sponsors of self-funded plans must report and pay the annual Patient Centered Outcomes Research Institute (PCORI) fee by filing IRS Form 720. Plans with plan years that end between October 1, 2020 and December 31, 2020, will need to pay the fee by August 2, 2021. For plan years that end on or after October 1, 2020, and before October 1, 2021, the fee is $2.66 per covered life.

Model COBRA Election Notices. The DOL Model COBRA Election Notice should be sent to qualified beneficiaries who experience qualifying events before September 30, 2021, but only if the qualifying event occurred after April 1, 2021. Notice of expiration only needs to be sent to AEIs whose subsidies will end by

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September 30, 2021, pursuant to ARPA.

Retirement Plan Compliance Deadlines and Reminders

Annual Funding Notice. Calendar year defined benefit plans with 100 or fewer participants (i.e., small plans) must provide an annual funding notice to required recipients by the earlier of the Form 5500 due date or the date of the Form 5500 filing, including extensions. Calendar year defined benefit plans with 100 or more participants (i.e., large plans) must provide an annual funding notice to required recipients within 120 days after the close of the plan year.

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