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HEALTH AND WELFARE PLAN DEVELOPMENTS

Agencies Issue Final Transparency in Coverage Rule

On October 29, 2020, the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury (collectively, the Departments) published the final version of the Transparency in Coverage rule. First proposed in November 2019, the rule imposes new transparency requirements on group health plans and health insurers. The final version of the rule is largely consistent with the proposed version, but modifies certain definitions and procedures to clarify requirements.

Under the final rule, most health insurers offering non-grandfathered health insurance coverage and most non-grandfathered group health plans will be required to make available to participants, beneficiaries and enrollees personalized out-of-pocket cost information, as well as the underlying negotiated rates, for all covered health care items and services. Affected plans and insurers will be required to make this information available through an online self-service tool, as well as in paper form upon request. A list of 500 services to be determined by the Departments must be available via the online tool for plan years beginning on or after January 1, 2023. All other items and services must be available via the online tool for plan years beginning on or after January 1, 2024.

Additionally, affected plans and insurers will be required to make three separate machine readable files containing detailed pricing information publicly available. The first file must show negotiated rates for all covered items and services between the plan or insurer and in network providers. The second file must show both the historical payments to, and billed charges from, out-of-network providers. In order to protect patient privacy, a minimum of 20 historical payments must be included. Finally, the third file must explain the in network negotiated rates and historical net prices for all covered prescription drugs by plan or insurer at the pharmacy location level. These three files will need to be in a standardized format and updated on a monthly basis. They are required to be made public for plan years beginning on or after January 1, 2022.

DOL Finalizes Update to Mental Health Parity Self-Compliance Tool

The U.S. Department of Labor (DOL) has finalized the biennial update to its self compliance tool for employers seeking to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). The final tool includes minor modifications from the proposed tool that was released in June 2020 to incorporate public comments.

Similar to the 2018 edition of the tool, the newly finalized tool devotes significant attention to instructing plans on how to identify potential non-quantitative treatment limits, including illustrating additional "warning signs" of MHPAEA noncompliance. For example, a new note explains that a non quantitative treatment limit exists when a plan covers room and board for intermediate inpatient medical/surgical care (such as at a skilled nursing facility), but imposes restrictions on coverage for room and board at residential facilities for mental health/substance abuse issues.

One of the significant updates to the final tool is the addition of a new "warning sign" for use of non comparable processes to determine reimbursement rates for medical/surgical benefits and for mental health/substance abuse benefits. For example, if a plan considers factors such as treatment outcome for setting reimbursement rates for mental health and substance abuse benefits, but sets reimbursement rates for medical/surgical benefits based only on factors such as geographic location and market dynamics, an impermissible non quantitative treatment limit may exist. The guidance states that comparing a plan's average reimbursement rates paid to both medical/surgical providers and mental health/substance abuse providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's reimbursement rates warrants additional review for compliance with MHPAEA. Appendix II of the updated tool includes an example table that plans may use to perform such an analysis.

The final update includes a reminder that plans that delegate benefit management to outside service providers should ensure that service providers for both medical/surgical benefits and mental health/substance abuse benefits maintain sufficient documentation to show compliance with MHPAEA.

IRS Announces 2021 Cost-of-Living Adjustments for QSEHRA and Adoption Assistance Benefits

In Revenue Procedure 2020-54 (Procedure), the Internal Revenue Service (IRS) announced 2021 cost of living adjustments (COLAs) for numerous tax-related limits. The maximum amount of payments and reimbursements under a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) will increase from

$5,300 for self-only coverage and $10,700 for family coverage. Additionally, the maximum amount that may be excluded from an employee's gross income under an employer provided adoption assistance program for the adoption of a child will be increased to $14,440. The Procedure also announced that for 2021, the dollar limit on employee salary reduction contributions to health flexible spending accounts (FSAs) will remain unchanged at $2,750. Additionally, the monthly limit on the amount that may be excluded from an employee's income for qualified parking benefits will remain $270. Finally, the dependent care flexible spending account (FSA) maximum, which is set by statute and is not subject to inflation related adjustments, will remain at $5,000 a year for individuals or married couples filing jointly, or $2,500 for a married person filing separately.

Sixth Circuit Holds That Plan Provisions Which Indirectly Discriminate Against Individuals with ESRD Can Violate MSP Rules

On October 14, 2020, the Sixth Circuit ruled that a dialysis provider can proceed with its claim for violation of the Medicare secondary payer (MSP) rules against an employer and third party administrator (TPA). The decision, which overturned a lower court's decision to dismiss the claim, could have significant implications for plans seeking to place limits on payments for dialysis treatment.

The case concerns the Marietta Memorial Hospital Employee Health Benefit Plan (Plan), a self-funded plan under the Employee Retirement Income Security Act of 1974, as amended (ERISA) administered by Marietta Memorial Hospital and a TPA, Medical Benefits Mutual Life Insurance Co., which placed four significant limits on reimbursement for dialysis treatment. First, all dialysis providers were classified as "out of network" and subject to the Plan's lowest rate of reimbursement. Second, rather than reimbursing dialysis providers based on the "reasonable and customary" cost of treatment, as it did with all other providers, the Plan stated dialysis providers were entitled to payment equal to no more than 125 percent of the Medicare fee. Third, for the cost of the dialysis service itself, the Plan would only reimburse at 87.5 percent of the Medicare rate. Finally, the Plan provided that payment for dialysis would be subject to heightened scrutiny, including "cost containment review."

A participant in the Plan, identified in court documents as "Patient A," began receiving dialysis treatment from Davita and incurred significant out of pocket costs due to the Plan's limits on reimbursement. Patient A eventually dropped Plan coverage and switched to Medicare, to which they were entitled by virtue of having end stage renal disease (ESRD).

In late 2018, Davita filed suit against the Plan and its TPA, on behalf of itself and as the assignee of Patient A. The complaint alleged that by offering inferior benefits to individuals with ESRD, the Plan unlawfully incentivized such individuals to drop Plan coverage and join Medicare. The district court eventually dismissed the claims, finding that cause of action under the MSP rules is only available to sue for recovery of payments that Medicare had made to a provider when a plan failed to make the payments. Further, the court found that even if a private cause of action was available, the Plan had not discriminated unlawfully against individuals with ESRD because the provisions applied equally to all participants.

Overturning the district court's dismissal, the Sixth Circuit ruled that the antidiscrimination provisions of the MSP rules prohibit indirect, as well as direct, discrimination against individuals with ESRD. It found that Davita plausibly alleged that the Plan violated the antidiscrimination provisions by subjecting the primary treatment for individuals with ESRD to special limitations. The case, *Davita, Inc. v. Marietta Memorial Hospital Employee Benefit Health Plan*, will now return to the district court. A similar case, *Davita v. Amy's Kitchen*, is currently on appeal to the Ninth Circuit.

IRS Publishes Forms 1094, 1095 and Related Instructions for 2020

On October 14, 2020, the IRS released final Forms 1094 and 1095 B, Forms 1094 and 1095 C, along with related instructions, for the 2020 tax year. Except for information regarding individual coverage health reimbursement accounts, both sets of forms and instructions are largely unchanged from 2019. The due dates on the materials have been updated and reflect the extension of time for furnishing individual statements to March 2, 2021.

RETIREMENT PLAN DEVELOPMENTS

District Court Rules Suit Against TPA Related to Cybertheft May Proceed

The Northern District of Illinois has ruled that a participant may proceed with her claim for breach of fiduciary duty against her retirement plan's TPA after an imposter used the TPA's online system to steal thousands of dollars from her retirement account. The complaint in *Bartnett v. Abbott Laboratories* was filed in April 2020, and reported on in the May 2020 Benefits Counselor.

Over the course of two weeks in January 2019, a hacker took advantage of the TPA's benefits website and call support center to steal $245,000 from the plaintiff's retirement account. The plaintiff's complaint alleged the theft could have been prevented if the TPA required individuals to answer security questions before accessing an online account, verifying the phone number from which the participant was allegedly calling the support center was associated with the account, and notifying the participant of account activity via email, as was her stated preference, rather than by mail. The complaint included claims against both the plaintiff's employer and the TPA for breach of fiduciary duty. Both the TPA and the plaintiff's employer moved for dismissal.

The court dismissed all claims against the employer and its agents, noting that most of the individuals named as defendants were neither named nor functional fiduciaries. The TPA argued its motion to dismiss should also be granted because it did not act as a plan fiduciary and performed only ministerial functions. The court rejected this reasoning, noting that parties become fiduciaries when they exercise discretionary control or authority over a plan's management, administration or assets. The court found that the complaint sufficiently alleged that the TPA exercised discretionary control or authority over the plan's assets, most notably by allowing the disbursement of plan assets to the hacker. The ruling is a significant development in what could be the first case in a wave of litigation against plan fiduciaries relating to cybersecurity breaches.

IRS Announces 2021 Dollar Limits for Retirement Plans

In IRS Notice 2020 79 (Notice), the IRS announced the 2021 dollar limits and thresholds for retirement plans. Changes include the following:

- The limit on annual additions to 401(k) and other defined contribution plans will increase to $58,000.
- The annual limit on compensation that can be taken into account for contributions and deductions will increase to $290,000.
- The dollar amount determining the maximum account balance in an employee stock ownership plan subject to a five year distribution period is increased to $1,165,000.

The Notice also provides that numerous other limits, including the threshold for being considered a highly compensated employee, the annual limit on elective deferrals, and the annual limit on catch-up contributions, will remain unchanged for 2021.

DOL Issues Final Rule on ESG Investing

As reported on in the July 2020 Benefits Counselor, in June 2020 the DOL published a proposed rule intended to clarify fiduciary duties under ERISA when using environmental, social and governance (ESG) factors in investment strategies. On October 20, 2020, the DOL released the final version of the rule, titled "Financial Factors in Selecting Plan Investments." Although the final rule is largely similar to the proposed rule, a handful of significant changes are included.

Notably, the text of the final rule does not contain any specific references to ESG or ESG themed funds. In a press release, the Employee Benefits Security Administration explained they decided the "ESG" terminology was not appropriate as a regulatory standard after receiving public comments expressing concern over the singling out of ESG funds and, more significantly, the fact that there is no generally accepted definition of ESG. Instead, the final rule refers only to pecuniary factors and non-pecuniary factors in defining the relevant fiduciary investment duties.

The proposed rule contained a blanket prohibition on any fund that used ESG factors or similarly oriented assessments from being a qualified default investment alternative (QDIA), even if those factors were used for pecuniary purposes. In contrast, the final rule only excludes a fund from being a QDIA if its investment objectives, goals or principal investment strategy include, consider or indicate the use of one or more non-pecuniary factors.

The final rule also omits references to situations where investments are "economically indistinguishable." Instead, the final rule provides that if after completing an appropriate evaluation of investment options a fiduciary cannot distinguish between them on the basis of pecuniary factors and the fiduciary chooses one of them on the basis of a non-pecuniary factor, then the fiduciary must document why pecuniary factors alone did not provide a sufficient basis on which to make a selection. Additionally, the fiduciary must document why pecuniary factors alone did not provide an adequate basis upon which to make a decision, how the chosen investment compares to other factors listed in the final rule, and how the chosen non-pecuniary factor or factors are consistent with the interest of participants and their retirement benefits under the plan.

The final rule becomes effective 60 days after the date of publication in the *Federal Register*. Plans have until April 30, 2022 to make any changes necessary to comply with the requirements related to the selection of QDIAs.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

SAR. For calendar year plans that obtained an extension to file their Form 5500, the plan's Summary Annual Report (SAR) must be distributed to participants and beneficiaries no later than two months following the expiration of the extension period (December 15, 2020). As explained in our May 2020 Benefits Counselor, the deadline for providing the SAR is tolled until 60 days after the announced end of the COVID-19 national emergency, provided the plan administrator acts in good faith and provides the SAR as soon as administratively feasible.

Health Plan Open Enrollment

1. SBC. Plan sponsors of group health plans must issue a new Summary of Benefits and Coverage (SBC) to participants and beneficiaries covered under the plan as part of the plan's open enrollment. Group health plans without open enrollment must issue the SBC no later than 30 days prior to the beginning of the next plan year (December 1, 2020 for calendar year plans).

1. HRA Opt Out. Plan sponsors of Health Reimbursement Arrangements (HRAs) must annually offer participants an opportunity to opt out of and waive all future reimbursements from their HRA. This opt out notice can be provided with annual open enrollment materials.

Retirement Plans

Defined Contribution Plan Annual Notices. Plan sponsors of defined contribution plans must annually provide the following notices, if applicable, at least 30 but not more than 90 days prior to the beginning of the plan year (between October 3 and December 1, 2020 for calendar year plans).

1. QDIA Notice. Plan sponsors of defined contribution plans that invest participant contributions in a QDIA for participants who fail to make an investment election must annually provide a QDIA notice to all participants.

2. Automatic Enrollment Notice. Plan sponsors of defined contribution plans with an eligible automatic contribution arrangement or a qualified automatic contribution arrangement must annually provide a notice to all participants on whose behalf contributions may be automatically contributed to the plan. This notice can be combined with the QDIA notice.

3. Safe Harbor 401(k) Notice. Plan sponsors of safe harbor 401(k) plans must annually provide participants a safe harbor notice that describes the safe harbor contribution and other material plan features. The safe harbor

notice can be combined with other required notices, such as the QDIA notice.