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RETIREMENT PLAN DEVELOPMENTS

IRS Sets Dates and Procedures for Cycle 2 Submissions for 403(b) Pre-Approved Plans

Employers with Internal Revenue Code (Code) section 403(b) pre-approved plans (*i.e.*, prototype and volume submitter plans) can soon take advantage of a second remedial amendment submission cycle (Cycle 2). The IRS announced in Revenue Procedure 2021-37 that the on-cycle submission period for Cycle 2 applications will extend from May 2, 2022 through May 1, 2023.

The procedures for the 403(b) pre-approved plan program will be similar to the Section 401(a) pre-approved plan program. Changes include:

- Eliminating the distinction between prototype and volume submitter plans;
- The issuance of a Cumulative List of Changes identifying requirements that the IRS will consider in reviewing Cycle 2 applications;
- Making reliance on an opinion letter more similar to the 401(a) pre-approved plan program, including the potential to submit an application for a determination letter using Form 5307 by an adopting employer of a nonstandardized plan that makes limited amendments, or an adopting employer of any 403(b) pre-approved plan (standardized or nonstandardized) that adds language to satisfy Code section 415 due to required plan aggregation; and
- Providing details on the system of cyclical remedial amendment periods that follows the initial remedial amendment period.

Additionally, for non-governmental plans, the IRS extended the deadline for making interim plan amendments with respect to a change in Code section 403(b) requirements to the end of the second calendar year following the calendar year in which the change in requirements is effective for the plan. For governmental 403(b) plans, the deadline is the later of this second calendar year or 90 days after the close of the third regular legislative session of the legislative body with the authority to amend the plan that begins on or after the date the plan amendment becomes effective.

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Further, the IRS provided that the limited extension of the Initial Remedial Amendment Period for certain Form Defects first occurring during Cycle 1 will end on the last day of the Cycle in which an application for an opinion letter that considers the Form Defect may be submitted. The deadline to adopt the initial amendment that qualifies the plan for this extension must be adopted by the later of June 30, 2020, or the end of the second calendar year following the calendar year in which the change in section 403(b) requirements is effective for the plan.

The IRS also provided rules for permitting the participation of certain church-related organizations in a 403(b) pre-approved plan intended to be a Retirement Income Account. These include special rules for amending a Cycle 1 403(b) pre-approved plan intended to be a Retirement Income Account to allow employees of certain church-related organizations to participate retroactive to the beginning of Cycle 2.

IRS Modifies the Interim Amendment Deadline For 401(a) Pre-Approved Plans

In Revenue Procedure 2021-38, the IRS modified the interim amendment deadline for Code section 401(a) pre-approved plans. An interim amendment made to a 401(a) pre-approved plan will be timely if adopted by the end of the second calendar year after the calendar year in which the change in qualification requirements is effective for the plan. This change to the interim amendment deadline is consistent with the deadline for adopting interim amendments with respect to 403(b) pre-approved plans. The Revenue Procedure applies to disqualifying provisions that are effective with respect to a plan after December 31, 2020.

This change has collateral consequences. An employer's tax-filing deadline is now irrelevant in determining the date by which an interim amendment must be adopted. Another result of the change is that the interim amendment deadline in Revenue Procedure 2016-37, which applies to governmental plans and is determined by reference to the interim amendment deadline for non-governmental plans, is also modified. Further, the modification means that the special rule for determining the tax-filing deadline applicable to a tax-exempt employer under Revenue Procedure 2016-37 is no longer relevant, and therefore has been eliminated.

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HEALTH PLAN DEVELOPMENTS

Agencies Propose Regulations for No Surprises Act Provisions Related to Air Ambulance Reporting

On September 10, 2021, the U.S. Department of Labor (DOL), Department of Health and Human Services (HHS), and Treasury (the Departments) announced proposed rules that would implement the provisions of the No Surprises Act that require group health plans and health insurance issuers to report on air ambulance services. By submitting reports to HHS, group health plans and issuers offering group coverage would satisfy the parallel requirements for reports under the Public Health Service Act, the Employee Retirement Income Security Act (ERISA) and the Code, as amended by the No Surprises Act.

Specifically, the proposed rules for reporting by plans and issuers describe the data reporting requirements, such as the general requirements, the timing and form of the data submission, and the reporting requirements when a transfer of business occurs. Reporting would be required on a calendar year basis. The data with respect to a calendar year would include both data relevant to air ambulance services furnished within the calendar year, as well as data relevant to services for which payments were made within the calendar year (even if the service was provided in a different calendar year). Plans and issuers would be required to submit the data for calendar year 2022 by March 31, 2023, and the data for calendar year 2023 by March 30, 2024. Plans and issuers would not need to submit a report if they did not receive claims or make or expect to make payments for air ambulance services with respect to the reporting period.

ACA Affordability Standard Shrinks for 2022

The Affordable Care Act (ACA) threshold for when employer-provided health coverage is considered affordable will decrease for 2022, according to IRS Revenue Procedure 2021-36. Employers will provide affordable coverage for the 2022 plan year when the employees' contributions for the lowest-cost, self-only coverage providing minimum value available to them are no more than 9.61 percent of their household income. For 2021 plan years, the threshold was 9.83 percent. Accordingly, coverage that was affordable for 2021 may no longer be affordable for 2022, even if employers do not change their employees' required contributions. Employers with 50 or more full-time employees (or full-time equivalent employees) that may be subject to employer shared responsibility penalties should evaluate whether their employee coverage will be affordable for 2022.

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Certain Transparency Requirements Delayed for Health Plans

The Departments issued FAQs addressing many of the transparency requirements for health plans under the Transparency in Coverage regulations and the Consolidated Appropriations Act, 2021 (CAA). The Departments announced they will delay enforcement of certain requirements and provided compliance guidance on other statutory requirements for which they will not delay enforcement.

The Departments will delay enforcement of the following requirements:

- Machine-Readable Files. Non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets will not be required to post a machine-readable file with negotiated rates and historical net prices for covered prescription drugs on a public website until the Departments issue further rules. In addition, plans and issuers will not need to post machine-readable files with in-network provider rates and out-of-network allowed amounts and billed charges until July 1, 2022, or the month in which the 2022 plan year or policy year begins, if later.

- Price Comparison Tools. Originally set to apply for plan or policy years beginning on or after January 1, 2022, the Departments delayed the CAA's requirement for an online price comparison tool, and for the provision of the same information over the telephone upon request, until the plan or policy year beginning on or after January 1, 2023. This date aligns with when non-grandfathered group health plans and health insurance issuers first must comply with the Transparency in Coverage rule's online price comparison tool requirement. The Departments also announced their intent to publish regulations so that the price comparison tool required under the CAA will be subject to the same standards as the price comparison tool required under the Transparency in Coverage regulations. Accordingly, plans and issuers can expect to need to comply with the Transparency in Coverage regulations and provide pricing information via an online tool, or in paper form or over the telephone upon request.

- Good Faith Estimates by Providers. HHS will delay enforcing the CAA requirement for providers to notify health plans and issuers of their good faith estimate of costs when patients schedule services. This delay will be effective until HHS issues further regulations.

- Advanced Explanations of Benefits. The Departments will not enforce the CAA

requirement that plans and issuers provide an Advanced Explanation of Benefits (Advanced EOB) to a covered person after receiving the provider's good faith estimate for the covered person's scheduled service. As with the delay for the good faith estimate, the Departments will not enforce the Advanced EOB requirement until they issue future regulations.

- Reporting of Pharmacy Benefits and Drug Costs. The Departments will not enforce the requirement that plans and issuers report data related to prescription drug expenditures for the original first reporting deadline of December 27, 2021 and the second reporting deadline of June 1, 2022. Thereafter, enforcement will depend on the issuance of regulations or further guidance. The Departments are encouraging plans and issuers to ensure that they can begin reporting 2020 and 2021 data by December 27, 2022.

The Departments also indicated that they expect plans and issuers to implement other aspects of the CAA's transparency requirements without regulatory guidance before January 1, 2022, and without delay. The FAQs explain that the Departments will not be issuing regulations addressing the CAA's health plan or insurance identification card, provider directory, balance billing disclosure, or continuity of care requirements prior to January 1, 2022, when the provisions may first apply for plans and issuers. The FAQs provide examples of what the Departments will consider good faith compliance for these requirements.

In contrast, the FAQs warn that plans and issuers should not expect regulations on the CAA's currently-effective prohibition against gag clauses on price or quality data in provider, network, or third-party administrator contracts. The Departments consider the CAA's prohibition against gag clauses to be self-implementing. Therefore, they do not plan to issue regulations on the prohibition, which was effective for agreements entered into by plans and issuers on or after December 27, 2020. However, plans and issuers can expect guidance on how to submit attestations of compliance in 2022.

The FAQs also note that grandfathered plans are generally subject to the requirements under the CAA.

Agencies to Revise Religious and Moral Exceptions for Contraceptive Coverage

The DOL, HHS, and Treasury recently announced that they intend to initiate rulemaking by mid-February 2022 to amend the 2018 final regulations that provide religious and moral exemptions for the ACA's contraceptive coverage

requirement. The ACA requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to cover contraception and contraceptive services for women without cost-sharing when provided in-network. The 2018 final regulations expand exemptions for entities with religious or moral objections to the contraceptive coverage requirement to which their health plans would otherwise be subject.

Impact on Health Plans of President Biden's COVID-19 Action Plan

On September 9, 2021, President Biden announced an action plan to address the rise in COVID-19 infections (the Action Plan). Several aspects of the Action Plan have the potential to impact employer-sponsored health plans.

Employers with 100-Plus Employees Must Require Vaccinations or Weekly Tests

One prong of the plan focuses on vaccinating the unvaccinated. As a component of that, the President announced that the DOL's Occupational Safety and Health Administration (OSHA) will issue an Emergency Temporary Standard that will require all private-sector employers with 100 or more employees to ensure their workforce is fully vaccinated or require any workers who remain unvaccinated to produce a negative test result on at least a weekly basis before coming to work.

Under the CARES Act, non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage must cover, without cost-sharing, immunizations that have a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Accordingly, employees with non-grandfathered health coverage through an employer subject to the forthcoming OSHA Emergency Temporary Standard will be able to receive their COVID-19 vaccination for free through their health plan.

However, prior FAQ guidance issued jointly by the Departments indicates that the cost of the weekly COVID-19 testing for workers who choose to remain unvaccinated may not be covered by the worker's health coverage. In *FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 43* (FAQs Part 43), the Departments stated that COVID-19 testing for surveillance or employment purposes is not required to be covered without cost-sharing by non-grandfathered plans and policies under section 6001 of the Families First Coronavirus Response Act (FFCRA). According to the FAQs, testing to screen for general workplace health and safety (such as

employee "return to work" programs) is beyond the scope of section 6001 of the FFCRA. Accordingly, workers may need to pay for some, or for all of the cost of weekly COVID-19 tests required for them to continue working.

Preparing for Booster Shots

According to the Action Plan, the Administration is preparing for booster shots to start as early as the week of September 20, 2021, provided the Food and Drug Administration (FDA) grants authorization or approval for the boosters and ACIP issues a recommendation for their use. The Action Plan indicates that booster shots will be free. Booster shots would be subject to the same coverage requirements for non-grandfathered plans under the CARES Act as other COVID-19 vaccines. Accordingly, non-grandfathered plans and issuers will need to cover booster shots without cost-sharing starting no later than 15 business days (not including weekends or holidays) after the date ACIP makes an applicable recommendation.

GENERAL DEVELOPMENTS

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. 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 was July 31, 2021. However, for plans that obtained an extension, the Form 5500 must be filed by October 15, 2021.

Summary Annual Report Deadline for Calendar Year Plans. 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.

Retirement Plans

Annual Funding Notice. Calendar year defined benefit plans with 100 or fewer participants generally 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.

Health and Welfare Plans

Medicare Notice of Creditable Coverage. Plans that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether the drug coverage they have is creditable or non-creditable by October 15, 2021. The Centers for Medicare and Medicaid Services (CMS) has developed model disclosure notices.