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OVERVIEW FROM THE EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION GROUP

The 2020-2021 transition was anything but tranquil, even when it comes to something as prosaic as employee benefits. We saw two new pieces of significant benefits legislation: the Consolidated Appropriations Act, 2021 (the "CAA"), and the American Rescue Plan Act of 2021 ("ARPA"). We also saw a frenzy of 4th quarter rule-making from the outgoing Trump administration, much of which was stopped in its tracks with the introduction of the Biden administration. As is common when there is a change in administration, a regulatory freeze was imposed pursuant to which unpublished guidance was withdrawn for review and approval, and the effective dates of other guidance was postponed. All the while, plan sponsors were still responding to 2020 COVID-19 related legislation and looming deadlines under the Setting Every Community Up for Retirement Enhancement Act of 2019 (the "SECURE Act"). In this newsletter, we provide an overview of the guidance that emerged during this busy period, including ARPA and CAA as they impact pension and welfare plans, fringe benefits and student loan assistance. We briefly address the guidance and implementation freeze, and provide an overview of other important developments – all with the aim of helping plan sponsors digest and comply with new and often imminent compliance obligations.

JENNIFER STOKES
Partner, St. Louis
Leader, EBEC Group
jennifer.stokes@bclplaw.com
T: +1 314 259 2671

RICHARD ARENBURG
Partner, Atlanta
richard.arenburg@bclplaw.com
T: +1 404 572 6765

ADAM BRAUN
Partner, St. Louis
adam.braun@bclplaw.com
T: +1 314 259 2457

KYLE FLAHERTY
Partner, New York
kpflaherty@bclplaw.com
T: +1 212 541 2134

STEVEN SCHAFFER
Partner, Atlanta
steven.schaffer@bclplaw.com
T: +1 404 572 6830

LISA VAN FLEET
Partner, St. Louis
lavanfleet@bclplaw.com
T: +1 314 259 2326

SARAH BHAGWANDIN
Counsel, Denver
sarah.bhagwandin@bclplaw.com
T: +1 303 866 0214

DENISE ERWIN
Counsel, Denver
denise.erwin@bclplaw.com
T: +1 303 866 0631

CASTLES HOLLIS
Counsel, Atlanta
cass.hollis@bclplaw.com
T: +1 404 572 6676

SERENA YEE
Counsel, St. Louis
sfyee@bclplaw.com
T: +1 314 259 2372

J. PATRICK BECKER
Associate, Atlanta
patrick.becker@bclplaw.com
T: +1 404 572 6786

STEPHEN EVANS
Associate, St. Louis
steve.evans@bclplaw.com
T: +1 314 259 2387

RANDALL SCHERER JR.
Associate, St. Louis
randy.scherer@bclplaw.com
T: +1 314 259 2446

JONATHAN HULL
Paralegal, St. Louis
jhull@bclplaw.com
T: +1 314 259 2359

JULIE WAGNER
Paralegal Specialist, St. Louis
jawagner@bclplaw.com
T: +1 314 259 2637

THE AMERICAN RESCUE PLAN ACT OF 2021

100% COBRA Subsidy from April 1, 2021 Until September 30, 2021

By Patrick Becker & Lisa Van Fleet

ARPA provides that, for the period from April 1, 2021 until September 30, 2021, if an individual's Consolidated Omnibus Budget Reconciliation Act ("COBRA") qualifying event is an involuntary termination of employment or a reduction of hours (each, an "assistance eligible individual"), then 100% of the COBRA premium is paid by the employer, health plan, or insurer and the premium expense is reimbursed by the federal government through a refundable FICA tax credit. For an insured or self-insured plan, the employer applies for the tax credit; however, a multiemployer plan will apply direct for the tax credit.

The subsidy is available for both assistance eligible individuals as well as their dependents electing COBRA, but is not available for anyone who voluntarily ends their employment. The subsidy will end on the earliest of (1) the expiration of the assistance eligible individual's maximum 18-month COBRA period, (2) the individual's eligibility for another group health plan or Medicare, or (3) September 30, 2021 (when the temporary subsidy under ARPA ends).

The termination of employment or reduction of hours may have occurred prior to the effective date of ARPA. A new 60-day election period is created for individuals who had an involuntary termination of employment or reduction in hours within the last 18 months and did not timely elect COBRA or dropped COBRA coverage. The election period begins on the date that the individual receives the new COBRA notice.

An employer may elect to permit assistance eligible persons to change their election to other plan options that have the same or lower cost premiums. Employers must update COBRA notices previously sent to individuals eligible for the subsidy to describe the subsidy and the ability to elect different coverage (if permitted by the employer) and issue extended COBRA election notices to assistance eligible individuals entitled to elect COBRA prior to April 1, 2021 by no later than May 31, 2021. Failure to issue these notices will be treated as a failure of COBRA's notice requirements. ARPA directs the Department of Labor to publish model notices for employers to utilize for the COBRA subsidy by April 11, 2021.

There are many unanswered questions about compliance with this new law – particularly how it is impacted by the tolling period requirements for COBRA elections and payment under **EBSA Disaster Relief Notice 2021-01** (see discussion below entitled *Department of Labor "Outbreak Period" Guidance*); how to determine whether a termination was "voluntary"; and the circumstances in which other coverage disqualifies the assistance eligible individual from subsidy eligibility. In addition, there are open questions regarding an employer's potential liability for underwithholding penalties and interest in the event the IRS disagrees with the employer's application of the COBRA subsidy provisions. Additional guidance implementing the COBRA subsidy provisions is expected and will hopefully include relief from penalties for good faith compliance -- and be issued in time to facilitate timely compliance.

Effective Date: April 1, 2021

Action Steps:

1. **Identify COBRA qualified beneficiaries who are assistance eligible individuals;**
2. **Reach out to "recently" terminated employees who did not elect COBRA coverage but who are now eligible for subsidized coverage; and**
3. **Update COBRA notices and prepare notices addressing the new requirements (as noted, the DOL model is due by April 11, 2021).**

Voluntary Continuation of Families First Coronavirus Response Act ("FFCRA") Leave

ARPA does not include any new paid leave requirements for private employers who were previously covered by the FFCA. Employers are, however, encouraged to continue to provide the paid sick leave and emergency family leave that was set forth in the FFCRA through the receipt of certain payroll tax credits for these wages. ARPA also provided for some expansions of the FFCRA and emergency paid sick leave of the FFCRA. Our employment colleagues have summarized these provisions on the BCLP At Work blog in a post you can read by **clicking here**.

Increase in Dependent Care Flexible Spending Account Limit for the 2021 Plan Year and CAA Relief to Reduce Forfeitures under Health and Dependent Care Flexible Spending Accounts

By Steve Evans

ARPA provides for a temporary one-year increase in the dependent care flexible spending account ("DFSA") limit to $10,500 (or $5,250 for individuals who are married but file separately). This change is effective for only the 2021 year. Employers who wish to provide for the increased limit must amend their Section 125 cafeteria plan no later than December 31, 2021, provided that the plan is operated consistent with the change prior to adoption of the amendment.

The CAA also included relief for employers that offer health flexible spending accounts ("HFSAs") and DFSAs. Under the CAA relief, employers may adopt temporary liberalized rules to help reduce employees' forfeitures during the ongoing pandemic. The CAA expanded upon prior relief provided under **IRS Notice 2020-29** and temporarily relaxes certain standard HFSA and DFSA rules for the 2021 and 2022 plan years. For more information and suggested actions employers should take, read our blog post by **clicking here**.

Single-Employer Pension Funding Relief

By Adam Braun

ARPA provides single employer defined benefit plan plans with relief in how they calculate plan obligations and funding shortfalls. First, ARPA permits amortization of funding shortfalls over 15 years instead of seven years, beginning in the 2019, 2020 or 2021 plan years (at the election of the plan sponsor). Second, ARPA extends prior legislation permitting pension interest rate smoothing (which was otherwise due to begin phasing out in 2021), while also modifying the interest rate floors and corridors set forth in that legislation. Both of these ARPA provisions can provide defined benefit plan sponsors additional flexibility and predictability in calculating their benefit obligations, and we recommend that plan sponsors consult with their actuaries on how best to take advantage of this relief.

Additional Relief for Multiemployer Plans

By Kyle Flaherty and Adam Braun

ARPA provides substantial funding assistance to certain troubled multiemployer pension plans and other forms of funding relief to all multiemployer pension plans generally.

First, a multiemployer plan may now elect to retain its prior year funding status for plan years that begin on or after March 1, 2020 and end on or before February 28, 2021, and critical or endangered multiemployer plans are not required to update their funding improvement or rehabilitation plans until the first plan year beginning after March 1, 2021. (However, multiemployer plans certified to be in critical funding status without regard to the election will be treated as a plan in critical status regardless of the election.)

Second, a multiemployer plan in critical or endangered status for a plan year beginning in 2020 or 2021 may extend its funding improvement period or rehabilitation plan period by five years.

Third, ARPA establishes a new Pension Benefit Guaranty Corporation ("PBGC") fund for certain troubled multiemployer pension plans pursuant to which each such troubled plan will be eligible to receive, as a lump sum, sufficient financial assistance to allow that plan to pay, in full, all pension benefits due from the plan through 2051. To qualify for this special financial assistance, a multiemployer pension plan must have been:

- in "critical and declining" status in any plan year beginning in 2020 through 2022;
- approved for a suspension of benefits by the U.S. Department of the Treasury as of March 11, 2021;
- in "critical" status in any plan year beginning in 2020 through 2022, has a funded percentage of less than 40% and has a ratio of active to inactive participants which is less than 2 to 3; or
- insolvent after December 16, 2014 and has remained insolvent and was not terminated as of March 11, 2021.

Additional regulations regarding how to apply for financial assistance from this new PBGC fund will be promulgated by mid-July 2021, and any application must be submitted to the PBGC by December 31, 2025.

Finally, like with single-employer defined benefit plans, ARPA provides for certain relief with respect to the assumptions and amortization rates used in calculating a multiemployer plan's funded status, including the smoothing of certain investment losses over 30 years instead of 15.

Expansion of "Covered Employees" Under Section 162(m) Beginning in 2027

By Steve Evans

ARPA expands the group of "covered employees" under Section 162(m) Internal Revenue Code ("Code") for which a company's compensation expense deduction is limited to $1 million each tax year. Under current law, the group of covered employees subject to this limitation generally includes the CEO, CFO, the company's next three highest compensated officers, and any of the preceding individuals who were previously included in the group of covered employees for any tax year beginning after December 31, 2016. Under ARPA, the group of covered employees is expanded to also include a company's five highest compensated employees who are not the CEO, CFO, or among the three highest compensated officers. The expanded group of the five highest compensated employees is determined each tax year, and the employees in this group are not automatically included in future years. This change is effective for tax years beginning after December 31, 2026.

DEPARTMENT OF LABOR GUIDANCE ON THE DURATION OF THE COVID-19 "OUTBREAK PERIOD"

Department of Labor Guidance on the Duration of the COVID-19 "Outbreak Period"

By Steve Evans, Serena Yee, and Sarah Bhagwandin

The Internal Revenue Service ("IRS") and Department of Labor ("DOL") issued EBSA Disaster Relief Notice 2021-01, which provides guidance on the duration and expiration of the COVID-19 relief provided under the IRS and DOL's "outbreak period" guidance issued last year. Under the prior outbreak period guidance, certain deadlines under employee benefit plans were "tolled" during the period beginning March 1, 2020, until the date that is 60 days after the announced end of the COVID-19 national emergency or such other date announced by the IRS and DOL. For more information on last year's outbreak period guidance, please read our prior blog post by **clicking here**.

Under EBSA Disaster Relief Notice 2021-01, the IRS and DOL clarified that the deadline relief under the prior outbreak period guidance will be disregarded until the earlier of (i) one year from the date the individual or the plan was first eligible for the relief or (ii) 60 days after the announced end of the COVID-19 national emergency. Upon expiration of the relief, the suspended timeframes for calculating deadlines under a plan will resume. In no event will the disregarded period for purposes of calculating a deadline extend more than one year. The determination of when the outbreak period relief ends must be determined on an individualized basis, and the guidance implies

that individualized notices must be provided to affected participants along with reissued or amended disclosures or notices previously provided to the participant.

The following are examples applying the guidance:

- A participant's COBRA continuation coverage election period commenced on March 1, 2020. Under the outbreak period guidance, the participant's 60-day election period was tolled effective March 1, 2020. Under EBSA Disaster Relief Notice 2021-01, the election period would be tolled until February 28, 2021, and the participant's full 60-day election period would commence March 1, 2021.
- A participant's COBRA continuation coverage election period commenced on February 14, 2020. Under the outbreak period guidance, the 60-day election period was suspended effective March 1, 2020. Under EBSA Disaster Relief Notice 2021-01, the suspension of the election period will end on February 28, 2021, and the individual will receive the balance of the election period beginning March 1, 2021, to elect coverage.

Action Steps

- Plan administrators should work with their service providers to identify individuals affected by the outbreak period guidance issued last year, determine the applicable deadlines that were suspended, and calculate the new deadlines under EBSA Disaster Relief 2021-01.
- Prepare notices to affected individuals describing the end of their outbreak period relief.
- Prepare new or amended notices and disclosures to send to affected individuals in connection with the expiration of their outbreak period relief. For individuals who may lose health coverage due to the expiration of the deadline relief, information concerning the expanded enrollment opportunities in the Health Insurance Marketplace should be provided.

THE CONSOLIDATED APPROPRIATIONS ACT, 2021

Partial Termination Relief for Retirement Plans

By Steve Evans

The CAA provides relief from the partial termination rule that applies to qualified retirement plans under Section 411(d)(3) of the Code. Under the general rule, a plan must provide that if it incurs a "partial termination" during the plan year, the "affected employees" will become 100% vested in their accrued benefits (to the extent funded) or the amounts credited to their account in the plan as of the date of the termination. Determining whether a partial termination has occurred is a detailed, "facts-and-circumstances" test. As a general rule, however, the IRS **considers a participant turnover rate of at least 20%** during a plan year to create a rebuttable presumption that a partial termination has occurred.

The CAA provides relief from the general rule so that a partial termination will not occur during any plan year which includes the period beginning on March 13, 2020, and ending on March 31, 2021, if the number of active participants covered by the plan is at least 80% of the of the number of participants who were covered by the plan on March 13, 2020.

Observations/Action Items

1. As enacted, the CAA provides relief from incurring a partial termination during the entirety of the 2020 and 2021 plan years for calendar year plans, as these plan years will both include the period of March 13, 2020, to March 31, 2021. We expect that the IRS may clarify this application in future guidance.
2. Plan sponsors who laid off or furloughed employees, or who have experienced large numbers of employee terminations, over the last 12 months should review their particular facts and circumstances and work with their third-party service providers and legal counsel to determine

whether a partial termination occurred. If a partial termination was previously determined to occur but would not have occurred under the CAA relief, a plan sponsor may need to determine the vesting obligations for participants who cease participation or request distributions going forward.

3. Importantly, the CAA relief does not require that the same participants return to active participant status and instead only requires that the raw number of active participants is at least 80% of participants covered by the plan on March 13, 2020.

In-Service Age 55 Distributions under Certain Multiemployer Plans

By Steve Evans

The CAA amended Section 401(a)(36) of the Code to permit certain building and construction industry multiemployer plans to make in-service distributions. Under the new provision, construction industry multiemployer plans (as defined in Section 4203(b)(1)(B)(i) of the Employee Retirement Income Security Act of 1974 ("ERISA")) are permitted to make distributions to employees who have attained age 55, have not separated from employment, and were participants in the plan on or before April 30, 2013, provided:

1. ithe plan's trust was in existence before January 1, 1970 and
2. before December 31, 2011, at a time when the plan provided that distributions may be made to employees who have attained age 55 and who have not separated from employment, the plan had received at least one written determination letter from the Internal Revenue Service stating that the plan was a qualified trust under Section 401(a) of the Code.

Consolidated Appropriations Act: Requiring Transparency in Mental Health Parity Compliance

By Serena Yee

Among the requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is that a group health plan's application of nonquantitative treatment limitations ("NQTLs") to mental health or substance use disorder benefits is comparable to its application to medical/surgical benefits.

New Analyses and Documentation Requirements

The CAA seeks to enhance transparency with respect to compliance with this aspect of the MHPAEA by requiring group health plans that impose NQTLs (e.g., medical management standards, prescription drug formulary, step-therapy protocols, admissions standards and limitations on inpatient services) to any mental health or substance use disorder benefit to conduct comparative analyses that include the following:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
- Every factor used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits and the evidentiary standards used for such factors, when applicable, and any other source or evidence relied upon to design and apply the NQTLs.
- The comparative analyses demonstrating that the process, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.
- The specific findings and conclusions reached by the group health plan, including any results that

indicate that it is or is not in compliance.

While an analysis of plan design has always been necessary for a group health plan to determine its compliance with the MHPAEA, the Act takes this a step further by requiring group health plans to document their comparative analyses and make them available to a state authority, the DOL, or the U.S. Department of Health and Human Services ("HHS") upon request.

Effective Date

The enhanced comparative analyses requirement became effective on February 10, 2021 (45 days after enactment of the CAA). Yet, the DOL, HHS, and IRS have until June 27, 2021 (18 months after the enactment of the CAA) to issue guidance, including clarifying information and illustrative examples, on this new requirement.

Action Items

Plan sponsors of a group health plan subject to the MHPAEA should not wait until guidance is issued to act. Although it seems unlikely that a plan would have to furnish its comparative analyses under the enhanced transparency requirement before the issuance of guidance, the Departments have stated that ensuring compliance with requirements related to mental health and substance use disorder parity is among their enforcement priorities. With this renewed focus on the MHPAEA and ongoing litigation, plan sponsors of self-insured health plans providing mental health or substance use disorder benefits should take the following actions:

- Review their most recent MHPAEA analysis to ensure that it continues to accurately reflect the plan's compliance with all existing parity requirements (an online self-compliance tool is available on the **DOL website**) and if necessary, take any corrective action; and
- Initiate discussions with their third-party administrators to ensure that the appropriate systems and procedures will be in place to satisfy the new transparency requirements.

"Surprise" Medical Billing Reforms

By Cass Hollis

The "No Surprises Act" ("NSA") was signed into law as part of the CAA. The purpose of the NSA is to prevent patients from receiving surprise medical bills and to increase transparency for patients as to the cost of medical services ahead of time. The NSA applies to group health plans, individual insurers in both the individual and group markets and certain health care providers and facilities. The NSA is generally effective on January 1, 2022.

Under the NSA, patients may not be billed for more than the in-network cost-sharing amount under their insurance plan for emergency services and certain other out-of-network services provided at in-network facilities, including air ambulance services but excluding ground ambulance services. In addition, the NSA requires health insurers to cover emergency services without prior authorization requirements or other limitations that are more restrictive than the requirements applicable to emergency services provided by in-network providers and facilities.

Surprise billing may apply for certain post-stabilization services and non-emergency services if the patient provides a consent waiver after receipt of a notice within 72 hours of the service. The notice must provide that the provider is out-of-network, a good-faith estimate of the charges, a list of in-network providers at the entity (if applicable) to which the patient can be referred, information on prior authorization requirements and a statement that consent is optional and that the patient can choose an in-network provider. Providers cannot request a consent waiver if there is no in-network provider available, the treatment is for unforeseen or urgent services or the provider is an ancillary provider that a patient does not select.

The NSA does not provide benchmark payments for services but provides for voluntary negotiations between insurers and providers followed by independent dispute resolution if the negotiations are unsuccessful. In the dispute resolution process, each party submits a best offer and the arbitrator selects one or the other. The party that is unsuccessful in the arbitration is required to pay the costs of the proceeding. In addition, the party seeking arbitration cannot seek to take the same party to arbitration for at least 90 day following a ruling.

The NSA provides significant protections for patients while placing many obligations on health plans, providers, facilities and insurers. Regulations related to the NSA are expected to be issued within the next year ahead of the NSA's effective date.

Designation of Primary Care Providers under the NSA

By Patrick Becker

Beginning with plan or contract years starting on or after January 1, 2022, group health plans and health insurers that require a participant, beneficiary or other enrollee to designate a primary care provider must allow the individual to designate any participating primary care provider acceptable to the individual. If the enrollee is a child, then the plan or insurer must allow the individual whose dependent is the child to select a physician (1) specializing in pediatrics and (2) participating in the network of the plan or insurer as the child's primary care provider.

Plans and insurers are also prohibited from requiring prior authorization or a referral for female enrollees seeking obstetrical or gynecological care provided by a health care professional (a) with relevant specialization (b) participating in the plan or insurer's network. This change does not waive any exclusions of coverage or preclude the obstetrician or gynecologist from notifying the enrollee's primary care physician or the plan or insurer of treatment decisions.

Employers with self-insured group health plans should review their plan documentation and coordinate with any third-party administrator to ensure that their plans are updated and administered properly.

New Requirements for Group Health Plan Insurance Identification Cards

By Randy Scherer & Patrick Becker

As part of the NSA, group health plans will be required to include certain information on insurance identification cards issues to participants and beneficiaries. Insurance identification cards must clearly indicate:

- Any deductible applicable to the plan (both in-network and out of network);
- Any out-of-pocket maximum applicable to the plan (both in-network and out-of-network); and
- A phone number and website through which the participant or beneficiary can find customer assistance information.

It is not clear what "customer assistance information" must be available via phone or web, but as an example, the text of the Act includes information regarding hospitals and urgent care facilities that offer services that are covered by the group health plan.

The new insurance identification card requirements apply with respect to plan years beginning on or after January 1, 2022.

Removal of Gag Clauses on Pricing and Quality Information

By Randy Scherer & Patrick Becker

As part of the NSA, group health plans may no longer enter into agreements with providers that would restrict the plan from:

- Providing provider-specific cost and quality information to participants, beneficiaries, individuals eligible to enroll in the plan, the plan sponsor, and referring providers;
- Accessing de-identified participant and

beneficiary claim and encounter information electronically upon request (consistent with HIPAA, GINA, and the ADA), including financial information, provider information, service codes, or any other data included in the claim or encounter; or

- Sharing the information or data discussed above (or directing it to be shared) with a Business Associate. [1]

Providers may continue to place reasonable restrictions on the public disclosure of the information described above. Group health plans will be required to submit an annual attestation to the DOL that they are in compliance with these provisions.

The provisions restricting gag clauses on pricing and quality information went into effect immediately. Although the provisions restrict entering into contracts with such gag clauses, guidance is needed to clarify if agreements already in effect that contain such clauses need to be modified.

Extension of Employer-Paid Student Loan Assistance through 2025

By Randy Scherer & Patrick Becker

A provision in the Taxpayer Certainty and Disaster Relief Act, part of the CAA, extends the tax exclusions for student loan repayment assistance made by employers on behalf of their employees through 2025. These exclusions, originally passed as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, permit employers to provide employees with student loan repayment assistance of up to $5,250 that is not subject to federal payroll and income taxes, as long as the assistance is made under an educational assistance program that meets the requirements of Section 127 of the Code.

The basic requirements for an educational assistance program to qualify for the exclusions include:

- A written plan outlining the program that is adopted by the employer;
- Reasonable notice of the availability and terms of the program provided to eligible employees;
- Eligibility in the program may not be limited in a way that discriminates in favor of highly compensated employees; and
- Participation in the program may not be offered in lieu of other benefits includible in gross income (i.e., cash payments).

Current estimates reflect that 45 million borrowers owe nearly $1.6 trillion in student loan debt. Employers who have not previously adopted an educational assistance program should consider their workforce and whether to take advantage of the recruitment and retention benefits provided by up to $26,250 in federal tax free student loan repayment assistance over the next 5 years.

Plan Sponsors Need to Prepare for Compliance with New Annual Reporting Requirement for Group Health Plans

By Denise Erwin

In order to increase transparency regarding pharmacy benefits and drug costs, Section 204 of the CAA requires every group health plan and every health insurance issuer that offers group or individual health insurance to submit annual reports to HHS, DOL and the Treasury providing detailed information regarding such costs starting one year from the date of enactment of the CAA. **The first report is due December 27, 2021** and subsequent reports are due each year by June 1.

The report must include the following information for the previous plan year:

- The beginning and end dates of the plan year

- The number of participants and beneficiaries
- Each state in which the plan is offered
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each such drug
- The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each such drug
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and for each of these drug, the change in amounts expended by the plan in each such plan year
- Total spending on health care services by the plan broken down by:
  - Types of costs:
    - Hospital, healthcare and clinical costs for primary and specialty care separately
    - Prescription drugs
    - Other medical costs including wellness services
  - Prescription drug spending:
    - By health plan
    - By participants and beneficiaries
- The average monthly premium
  - Paid by Employers
  - Paid by participants and beneficiaries
- Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan (or its administrators or service providers) with respect to prescription drugs prescribed to participants or beneficiaries, including:
  - The amounts so paid for each therapeutic class of drugs
  - The amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees and or other remuneration described above

Action Steps:

Plan sponsors should take steps now to ensure that they will be able to timely comply with this reporting requirement:

- Review content requirements and identify information that must be provided by service providers to the plan.
- Amend service agreements with third party administrators ("TPAs") and pharmacy benefit managers ("PBMs") to require that the information will be timely provided or that the reports will be prepared on behalf of the plan.
- Monitor responsible parties, including TPA and PBMs, to ensure full compliance in preparing and submitting the reports.
- Moving forward, the plan fiduciaries should consider the information provided in the reports to determine if it might be appropriate to take any action with respect to the plan and its service providers.

THINKING AHEAD IN 2021 AND BEYOND

Update on Q4 2020 Trump Administration Agency Rules

By Adam Braun

In the fourth quarter of 2020, agencies under the outgoing Trump administration proposed and finalized several rules that impact health & welfare and retirement plans. Upon taking office in January 2021, the Biden administration quickly moved to halt the implementation of some of these rules, and both the Biden administration and members of Congress signaled that it may seek to unwind others.

More specifically, in a January 20, 2021, **memorandum** to all heads of executive departments and agencies, the Biden administration issued a "regulatory freeze" on (i) all rules sent to the Office of the Federal Register but not yet published in the Federal Register, noting that such rules should be immediately withdrawn, and (ii) rules that had been published in the Federal Register but were not yet effective, noting that effectiveness of such rules should be delayed for at least 60 days for further review. The Biden administration also provided a non-exclusive list of agency actions that it intends to review in 2021 under the Executive Order titled "Protecting Public Health and the Environment and Restoring Science to Tackle the Climate Crisis" (the "Executive Order"). In addition, in the event that executive action is not taken, Congress may review and overturn any agency rules finalized after August 21, 2020, pursuant to its authority under the Congressional Review Act.

As of the date of this newsletter, the following rules that had been published but were not effective as of January 20, 2021 remain subject to administrative agency review as a result of the Executive Order:

- Prohibited Transaction Exemption 2020-02 (published Dec. 18, 2020), which permits certain fiduciaries providing investment advice to also offer other investment advisory services.

- The Interim Final Rule on Lifetime Income Disclosures (published Aug. 18, 2020), which requires defined contribution plans to provide lifetime income illustrations to participants to help them better understand their potential retirement income stream from their plan balance.

On March 10, 2020, the DOL announced that it will not enforce (or otherwise pursue enforcement actions against plan fiduciaries based on a failure to comply with) the following rules that became effective prior to January 20, 2021:

- The Environmental, Social, and Governance ("ESG") Rule (published Nov. 13, 2020, effective Jan. 12, 2021), which requires that plan fiduciaries select investments solely based on financial factors, without consideration of any environmental, social and governance factors.

- The Plan Fiduciary Proxy Voting Rule (published Dec. 16, 2020, effective Jan. 15, 2021), which can be considered to be subpart of the ESG Rule, requires that plan fiduciaries consider the financial significance of any proxy vote or exercise of stockholder rights and adopt policies and procedures regarding how such rights will be exercised.

Finally, amendments to the HIPAA Privacy Rule, which were originally released on December 10, 2020 and introduce significant changes to the administration and share of protected health information (PHI), were published in the Federal Register on January 21, 2021 – one day after the Executive Order. Comments were due March 22, 2021.

We will be watching closely to see what happens with these rules as 2021 unfolds.

SECURE Act – Recordkeeping for Long-Term, Part-Time Employee 401(k) Eligibility

By Adam Braun

Under the SECURE Act, beginning January 1, 2024, 401(k) plan sponsors must allow participation by part-time employees who provided at least 500 hours of service in three consecutive years. In light of the three-year lookback period for purposes calculating eligibility, 401(k) plan sponsors should begin keeping track of hours of service for their part-time employees in 2021.

In addition, while employer contributions for eligible part-time employees are not required under this rule, **IRS Notice 2020-68**, issued September 2, 2020, clarified that, for purposes of determining whether a long-term, part-time employee has become vested in employer contributions, 401(k) plan sponsors are required to provide service credit for each 12-month period in which that employee has at least 500 hours of service, including service prior to January 1, 2021. Therefore, to the extent that 401(k) plan sponsors intend to provide employer contributions to these long-term/part-time employees (which is not required by the SECURE Act), plan sponsors need to be prepared to credit any vesting schedules for such employees' service (including service prior to January 1, 2021) and manage their records accordingly.

The recordkeeping effort required by this new rule will require coordination now within the plan sponsor's HR function and its third party payroll providers to ensure that hours of service are being accurately captured and recorded. In addition, plan sponsors should begin thinking about (i) whether long-term, part-time employees should also be eligible to receive employer contributions and (ii) what documents and participant communications will need to be updated to reflect these changes. Plan amendments are due in the first plan year beginning on or after January 1, 2022.

DOL Electronic Delivery Safe Harbor for Retirement Plans

By Serena Yee & Sarah Bhagwandin

The DOL issued final regulations in 2020 supplementing the two long-standing safe harbors for electronic delivery of plan-related information to participants (*i.e.*, participant's use of a computer is part of his or her integral job duties and participant gives actual consent) with a new safe harbor that allows for delivery through a website or directly by email.

Covered Documents

The new safe harbor can be used by a retirement plan to distribute any documents or information required to be distributed under Title I of ERISA (e.g., summary plan descriptions, fee disclosures and blackout notices). However, the safe harbor does not apply to documents or information that must be furnished only upon request. In addition, the DOL explicitly states that the safe harbor is not applicable to any disclosures relevant to welfare benefit plans.

Documents distributed electronically under the new safe-harbor, whether posted through a website or sent directly to a covered individual (as defined below) by e-mail, must meet the following criteria:

- The document must be presented in a manner calculated to be understood by the average plan participant and be searchable electronically by number, letters or words; and
- The document must be presented in a widely-available format suitable for both reading online and printing on paper and can be permanently retained in an electronic format.

Covered Individuals

The new safe harbor is applicable only to participants, beneficiaries and other individuals who furnish the employer or plan administrator with an electronic address, which may include an email address or number to an internet-connected mobile-computing device (*e.g.*, a smartphone) at which the covered individual may receive a notice of internet availability (NOIA).

Methods for obtaining a usable electronic address include:

- Employer-assigned work email address to employee for employment-related purposes.

Assignment of an email address solely for the purpose of furnishing documents and information pursuant to this safe harbor is insufficient. The safe harbor prohibits plan administrators and plan service providers from assigning electronic addresses. Electronic addresses obtained through a commercial locator service also may not be used;

- Employee provides a personal electronic address to the plan administrator or plan sponsor as part of the job application process or on other human resource documents; or
- Individual provides an electronic address in connection with a request from the plan administrator or plan service provider on plan enrollment paperwork or to establish the individual's online access to plan documents and account information.

A spouse or other non-employee beneficiary entitled to ERISA disclosures must affirmatively provide the employer, plan sponsor or plan administrator with an electronic address.

A plan administrator may continue to rely on the new safe harbor for employees who have terminated employment. However, if the electronic address utilized by the plan administrator for purposes of the new safe harbor is the employer-assigned work email address, the plan administrator must take steps at the time of the employee's termination to either ensure the continued accuracy and availability of the former employee's electronic work address or obtain a new electronic address.

Initial Notice of Electronic Delivery

In order to rely on the new safe harbor, the plan administrator must notify each covered individual in writing (and in paper form) that covered documents will be furnished electronically to an electronic address. Such written notification must be written in a manner calculated to be understood by the average plan participant and must include the following information:

- Identification of the electronic address that will be used for the individual;
- Any instructions necessary to access the covered documents;
- Statement that the covered document is not required to be available on the website for more than one year or, if later, after it is superseded by a subsequent version of the covered document;
- Statement of the right to request and obtain a paper version of the covered documents, free of charge, and a description of how to exercise such right; and
- Statement of the covered individual's right, free of charge, to opt out of electronic delivery and to receive only paper versions of the covered documents with a description of how to exercise such right.

Internet Posting of Covered Documents

The safe harbor includes a number of requirements if the plan administrator intends to make covered documents available through a website.

- Standards for Internet Website
  - The plan administrator must ensure the existence of the internet website at which covered individuals can access the covered documents and that the website protects the confidentiality of personal information relating to any covered individual; and
  - The documents must be available on the website no later than the date on which the covered document is required to be furnished under ERISA and must remain available for at least one year or if later, the date it is superseded by a subsequent version of the covered document.

For purposes of the safe harbor, the term "website" refers to a traditional internet website as well as any other internet or electronic-based information repository, such as a mobile application, to which covered individuals have been provided reasonable access.

- Notice of Internet Availability ("NOIA")

  At the time a covered document is made available on the website, the plan administrator must furnish a NOIA to covered individuals using their respective electronic addresses. The NOIA must be furnished separately from any other documents or disclosures and must be written in a manner calculated to be understood by the average plan participant. Although the use of pictures, logos or similar design elements is permissible, the contents of the NOIA must be limited to:

- A prominent statement (*e.g.*, as the title, legend or subject line) that reads: "Disclosure About Your Retirement Plan";
- A statement that reads: "Important information about your retirement plan is now available. Please review this information";
- Identification of the covered document by name (*e.g.*, your quarterly benefit statement) and a brief description of the covered document if identification by name only would not reasonably convey the nature of the covered document to the covered individual;
- The internet website address or a hyperlink to the address that leads the covered individual either directly to the covered document or a login page that provides a prominent link to the covered document once the covered individual logs on;
- A statement of the covered individual's right to request and obtain a paper version of the covered document, free of charge, and a description of how to exercise such right;
- A statement of the covered individual's right, free of charge, to opt out of electronic delivery and to receive only paper versions of the covered documents with a description of how to exercise such right;
- A cautionary statement that the covered document is not required to be available on the website for more than one year or, if later, after it is superseded by a subsequent version of the covered document; and
- A contact number for the plan administrator or other designated plan representative.

The NOIA may include an optional statement as to whether any action on the part of the covered individual is invited or required in response to the covered document and how such action may be taken.

The plan administrator may furnish a combined NOIA each plan year for more than one covered document; provided the next plan year's combined NOIA is furnished no more than 14 months later.

The system for furnishing the NOIA must be designed to alert the plan administrator if a covered individual's electronic address has become invalid or inoperable (*e.g.*, undeliverable message). If the plan administrator is unable to remedy the situation (*e.g.*, obtain a new electronic address) timely, it must treat the covered individual as if he or she had elected to opt-out of electronic delivery and provide the covered document in paper form until a new electronic address is obtained.

Sending Covered Documents By Email

In addition to making covered documents available through a website, the new safe harbor provides an alternative approach to providing documents electronically. Plan administrators can email covered documents directly to the covered individual using the electronic address obtained from the individual. To satisfy the safe-harbor, the plan administrator must comply with the following:

- The administrator takes reasonable measures to protect the confidentiality of personal information relating to the covered individual;
- The covered document is sent by email (either in the body of the email or as an attachment) no later than the date by which the covered document is required to be furnished to the covered individual under ERISA;
- The subject line of the transmittal e-mail says, "Disclosure About Your Retirement Plan"; and
- The transmittal e-mail includes the following:
    - If the document is attached to the e-mail, rather than included in the body of the e-mail, identification of the covered document by name (*e.g.*, your quarterly benefit statement) and a brief description of the covered document if identification by name only would not reasonably convey the nature of the covered document to the covered individual;
    - A statement of the covered individual's right to request and obtain a paper version of the covered document, free of charge, and a description of how to exercise such right;
    - A statement of the covered individual's right, free of charge, to opt out of electronic delivery and to receive only paper versions of the covered documents with a description of how to exercise such right; and

- A contact number for the plan administrator or other designated plan representative.

Opt-Out Requirements

Covered individuals must have the right to globally opt-out of electronic disclosures, free of charge, and elect to receive a paper version of the covered documents. The administrator must promptly comply with an opt-out request from a covered individual. In order to satisfy the new safe harbor, plan administrators must adopt reasonable procedures for managing elections or requests to opt-out. The regulations expressly provide that a procedure is not reasonable if it unduly inhibits or hampers the initiation or processing of a request or election.

Has Anyone Heard From Harry Lately? – DOL Recommendations For A Fiduciary's Search For Missing Participants

By Sarah Bhagwandin

Plan fiduciaries have a duty to take reasonable steps to maintain a complete and accurate plan participant census. Nonetheless, according to the DOL, plan administrators routinely miss clear signs that their contact information for participants is flawed. The result is that participants do not receive important information about their employer-sponsored retirement benefits, in many cases resulting in benefits left in plans for years rather than paid to participants. In an effort to put a spotlight on practices that successfully create and maintain accurate participant data, the **DOL released a list of "Best Practices for Pension Plans"** for plan administrators of defined contribution and defined benefit plans. The DOL's tips-list is non-binding guidance, and part of the EBSA's nationwide compliance initiative to help retirement plans maintain complete and accurate plan records.

The DOL's focus on the importance of maintaining accurate participant information should lead plan fiduciaries to determine, along with their service providers, the following:

1. whether the participant census is well-maintained and what practices and procedures are in-place to keep plan records up-to-date;
2. 2how often communications to plan participants solicit updated contact information from plan participants;
3. what proportion of the retirement plan participants are considered unresponsive or "missing";
4. what practices are in place to identify when participants are missing; and
5. what practices are in place to locate missing participants.

Best Practices – Sample Practices that Help Keep Plan Records up to Date

Not all of the DOL's recommended practices will be useful to every plan, but their suggested procedures do provide plan administrators with useful direction. In some instances, a plan administrator may need to simply improve plan communications by making them clearer and using them to regularly solicit updated contact information from participants. In other instances, a plan administrator may identify systemic plan administration weaknesses that help create a stale and inaccurate plan census.

Here are a few of the DOL's "best practices" for plan administration intended to help keep plan records up to date:

- Periodically prompting plan participants to update their contact information;
- Adding requests for changes in contact information or confirmation of contact information to routine plan communications;
- Flagging undeliverable mail and e-mail and reaching out to participants for updated information (i.e. plan administrators should not repeatedly send mail to an address that has been identified as "undeliverable";
- Requesting and reviewing reports of uncashed/stale distribution checks from the record-keeper and following-up with participants;
- Updating onboarding and off-boarding procedures to obtain updated contact information and using onboarding and off-boarding to emphasize to employees the importance of keeping the plan apprised of their

current contact information;

- Maintaining and monitoring an online platform for the plan that participants can use to update their contact information;
- Documenting procedures and practices for reviewing employee data;
- Reviewing the ages of terminated vested participants to determine if there are more than a small number who have reached normal retirement age, but not taken their benefit;
- Adding a regular audit of the plan census to administrative procedures. An audit of a plan census would look for the following types of data to indicate that a participant's record is incomplete or inaccurate: missing spousal information, entries in fields that are clearly just place-holders (e.g. 00/00/1954 for a birthdate), partial social security numbers, incomplete information about birthdays.

Critical Events in the Life of a Plan that can Compromise an Accurate Census

Along with listing best practices for maintaining an accurate census, the DOL identified common events in the life of a plan when particular care should be given to protect the accuracy of plan data. These events are both natural opportunities to audit and perfect a plan census and transitions that can result in the census becoming inaccurate. When a plan is in the middle of an event listed below, plan administrators should take extra steps to protect the accuracy of the plan census.

- Changing Record-Keepers – Plan administrators should confirm that the records of unresponsive participants are carefully reviewed and updated before transferring a plan census to a new record-keeper. Transferring a flawed census can perpetuate the problem of missing or unresponsive participants, and lead to serious delays in resolving inaccurate information. The longer the period between the time a plan administrator becomes aware that a participant is unresponsive and the time the plan administrator takes action to locate that individual, the less likely the plan administrator will be successful. A plan administrator should run a missing participant search, which is described below, to attempt to resolve faulty records before transitioning a plan to a new record-keeper.
- Mergers & Acquisitions – When a company undergoes a business transaction, such as a merger, an acquisition, or a divestiture, it is easy for plan participants to lose contact with their retirement plan. This is especially true if the employer and/or plan undergo a name change and the plan communications/disclosures no longer carry the legacy names. It is easy for participants to ignore communications from a plan or employer whose name is unfamiliar to them.

  To combat this the DOL recommends 1) auditing the plan census as part of the collection and transfer of records to an acquiring entity; 2) confirming that the records of a predecessor plan are fully integrated into the successor plan's records, 3) clearly marking all envelopes and letters relating to plan information with the name of the legacy plan and employer, in addition to the new names. The DOL commented that it is easy for workers who may have participated in a predecessor plan or worked for companies of a different name to ignore correspondence when they don't recognize the names. In addition, we would advise that an acquired entity should document any irregularities in payroll information so that missing or unresponsive participants continue to be tracked by the acquirer.

Searching for Missing Participants – What are the right next steps?

Once a plan administrator has determined that a plan participant's record is inaccurate, and exhausted its internal means to resolve the record, it is time to launch a focused search. Many record-keepers provide participant searches as part of their menu of services, which makes them the logical first step for a plan administrator. But aside from the record-keeper, plan administrators have many tools for confirming the contact information of unresponsive participants, including but not limited to the following:

- Cross-checking plan records with the other employer-sponsored plan records;
- Engaging a commercial locator service, including conducting death searches;
- Utilizing free online search engines;
- Searching public record data bases, such as license records, mortgages, real estate taxes, obituaries;
- Credit report agencies;

- Reaching out to designated beneficiaries for updated contact information.

The DOL's guidance suggested some search techniques that may be inadvisable for a plan fiduciary for privacy reasons, such as reaching out to an employee's colleagues to solicit information or publishing a list of missing or non-responsive participants on the company's intranet. They also suggested that plan fiduciaries consider registering missing participants on public and private pension registries that have privacy and security protections, such as the National Registry of Unclaimed Retirement Benefits. There is some debate that identifying an individual as a missing participant who is eligible for a benefit under a retirement plan could result in fraud or identity theft against that individual. In any event, there is a wide range of options for attempting to make contact with plan participants.

Accurate plan records not only help ensure that participants are receiving plan communications, they significantly improve plan operations and help a plan achieve its end goal: preparing employees for retirement. This is a good time to review plan operations and consider adopting practices that help maintain an accurate plan census.

Required Amendments for Hardship Distribution Changes

By Adam Braun, Steve Evans, Julie Wagner, and Jonathan Hull

Code Section 401(k) and 403(b) plan sponsors should remember that plan amendments to effect the revised hardship withdrawal rules are due by December 31, 2021. Those revised rules, which were **issued by the IRS in September 2019**, made the following changes to administrative practices and plan terms regarding hardship distributions:

- Eliminated required 6-month suspension of elective deferral contributions following a hardship distribution;
- Removed requirement that participants take all available loans before taking a hardship distribution;
- Allowed hardship distributions to include earnings on deferrals (other than with respect to Code Section 403(b) elective deferrals); and
- Permitted hardship withdrawals for casualty losses without regard to whether the casualty loss is due to a federally declared disaster. Plan sponsors that want to permit these casualty loss safe harbor withdrawals should review their plan documents to determine if their plan disregards federally declared disaster requirement and, amend the plan.

Under the revised hardship distribution rules, plan sponsors may rely on an employee's representation that a distribution is necessary to satisfy an immediate and heavy financial unless the plan administrator has actual knowledge to the contrary. Plan amendments are required to: (1) remove any plan provision suspending an employee's contributions following a hardship distribution of elective deferrals and (2) require an employee's representation relating to his or her need for a hardship distribution, if the plan does not already provide for such a representation, and plan sponsors may opt into the other changes set forth in the revised rules. The amendments must be effective for hardship distributions made on or after January 1, 2020.

GETTING IN TOUCH

When you need a practical legal solution for your next business opportunity or challenge, please get in touch.

JENNIFER STOKES
Partner, Leader, Employee Benefits and Executive Compensation
jennifer.stokes@bclplaw.com

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