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INSIGHT

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Legislative Update

On December 21, 2020, Congress passed a $2.3 trillion omnibus appropriations and COVID-19 relief package, the *Consolidated Appropriations Act of 2021* (H.R. 133). On December 27th, President Trump signed the Act into law, after initially criticizing the amount individuals would receive in stimulus payments. The massive bill includes: 1) a $1.4 trillion appropriations package to fund the government through September 30, 2021; 2) a long-debated $900 billion COVID-19 relief and stimulus package; 3) funding for COVID-19 vaccines and testing; 4) expanded food aid programs; 5) emergency education relief; 6) airline and transportation support; 7) relief for farmers; 8) broadband incentives; and 9) extensions on eviction moratoriums.

The new stimulus bill also includes a large surprise medical billing package, a health transparency and patients' rights package, various tax extenders and other tax and health provisions, and a few miscellaneous retirement provisions. This is the largest health care legislative package since the Affordable Care Act (ACA), which suggests a very busy health regulatory year in 2021 under the Biden Administration.

The new surprise medical billing law prohibits balance billing for emergency services, certain non-emergency services furnished at an in-network facility by an out-of-network provider, and air ambulances. Furthermore, the law requires an independent dispute resolution process for instances in which group health plans and health insurance issuers are unable to negotiate reimbursement for such out-of-network providers. The new law also requires some additional consumer protections. For example, plans and issuers must: 1) provide an advance explanation of benefits (EOB) for scheduled services; 2) include specific cost-sharing requirements and consumer assistance information on plan ID cards; and 3) verify and update provider directories at least every 90 days and respond to individuals within one business day regarding the network status of a provider.

The new legislation also *permits* employers to adopt certain health and dependent care flexible spending arrangement (FSA) relief, but employers are not required to do so. This flexibility includes, among other things: 1) the carryover of unused balances from plan year in 2020 to plan year ending in 2021 and from plan year ending in 2021 to plan year ending in 2022; 2) extension of a grace period for a plan year ending in 2020 or 2021 to 12 months after the end of such plan year; and 3) election changes for a plan year ending in 2021, regardless of whether the employee had a permitted election change event. An employer can

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amend a cafeteria plan retroactively to provide for the changes, as long as the amendment is adopted no later than the end of the calendar year after the plan year in which the amendment is effective, and the plan is operated consistent with the terms of such amendment during the period beginning on the date of the amendment and ending on the date the amendment is adopted.

The bill has only a few miscellaneous retirement changes, including provisions allowing employers that had to furlough or lay off employees due to COVID-19 to avoid partial plan terminations, allowing money purchase pension plans to permit participants to take coronavirus-related distributions, and extending time limits for plan loans allowed under the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act).

Notably, the legislation did not include aid to state and local governments, as that proposal became a sticking point in negotiations. However, Democrats in Congress have vowed to come back to the issue of state and local aid in 2021. President Biden and Congressional Democrats have also called for an additional COVID-19 relief and stimulus package this year.

Other Notable Introduced Legislation:

- Senate Finance Committee Chairman Chuck Grassley (R-IA) together with Senators Maggie Hassan (D-NH) and James Lankford (R-OK), introduced the *Improving Access to Retirement Savings Act* (S. 5064), to allow 403(b) plans to participate in multiple employer plans (MEPs).
- Senate Finance Committee Ranking Member Ron Wyden (D-OR) introduced S. 5035 to make the Saver's Credit refundable into a retirement plan or IRA. It also includes a COVID-19 recovery bonus credit that provides up to $5,000 in additional government matching contributions for the first $10,000 saved during a five-year period beginning in 2022.
- Sen. Mazie Hirono (D-HI) and Rep. John Larson (D-CT) introduced the *Social Security COVID Correction and Equity Act* (S. 4986, H.R. 7499) to amend Social Security wage calculations to prevent reduced benefits for workers over age 60, in light of reduced hours and compensation in 2020.
- Rep. James Comer (R-KY) introduced the *Safeguarding America's Frontline Employees To Offer Work Opportunities Required to Kickstart the Economy Act* (H.R. 8832) or the "SAFE TO WORK Act" to "discourag[e] insubstantial lawsuits relating to COVID–19 while preserving the ability of individuals and businesses that have suffered real injury to obtain complete relief."
- Sen. Mike Braun (R-IN) introduced S. 4959 to require group health plans or group or individual health insurance issuers to annually report to the Secretaries of Health and Human Services and Treasury data on enrollment, total spending on care, prescription drug usage, monthly premiums, and more.

Governmental 457(b) Plan Primer

Many public sector employers may choose to offer 457(b) plans as an additional savings vehicle. These non-qualified plans must be funded with assets held in trust for the benefit of individuals participating in the plan. Usually, any state and local government employee may be allowed to participate, including part-time employees and seasonal workers, as well as independent contractors.

Eligible 457(b) plans allow employees to take advantage of tax deferrals up to the limits indicated in the following table (though a Roth option is allowed). In the past, 457(b) plans were not widely used due to a lower contribution limit. However, in 2001, the *Economic Growth and Tax Relief Reconciliation Act* (EGTRRA) raised the 457(b) contribution limit to be in line with the employee deferral limit for 401(k) and 403(b) plans, which broadened the use of 457(b) plans. Further, 457(b) plans allow two types of catch-up contributions, as outlined in the following table on page 3, which may allow members to double their maximum yearly contribution in some years.

Since these plans are non-qualified, 457(b) plans do not have a 10% penalty for early withdrawals – members may make withdrawals after severance from employment, regardless of age, and pay only the standard income tax rate on distribution.

The following table highlights the key features, rules, and resources for governmental 457(b) plans.

Governmental 457(b) Plans	
Features	**Rules and Resources**
Eligibility	Employees or independent contractors who perform services for a state or local government, political subdivision, or governmental agency. There is no nondiscrimination testing.
Employee Contributions	• Employees can make elective deferrals (pre-tax or Roth). • Elective deferrals are immediately 100% vested.
Employer Contributions	• Employers may make contributions, but are not required to do so. • Employer contributions may vest over time according to plan terms. • Employer contributions are subject to FICA taxes.
Contribution Limits	Total employee and employer contributions (not including catch-ups) cannot exceed the lesser of: • 100% of the member's includible compensation, *or* • The elective deferral limit ($19,500 in 2020 and 2021).

Catch-Up Contributions	• May allow catch-up contributions for members who are age 50 or older of up to $6,500 in 2020 and 2021;
	• May allow special 457(b) catch-up contributions that allow a member (who is not making age 50 catch-up contributions for that year) for the 3 years prior to the normal retirement age (as specified in the plan) to contribute the lesser of:
	  ◦ Twice the annual limit ($39,000 in 2020 and 2021), *or*
	  ◦ The basic annual limit plus the amount of the basic limit not used in prior years (age 50 catch-up contributions are not counted for this purpose).

Other Key Plan Features Allowed	• Automatic enrollment • Loans • Unforeseen emergency withdrawals • Rollovers to eligible retirement plans, such as 401(k) plans, 403(b) plans, other governmental 457(b) plans, or IRAs
Distributions and Taxation	Funds are taxed at distribution, and distributions are reported on IRS Form 1099-R. Distributable events include: • Attainment of age 59 ½ • Severance from employment • Unforeseeable emergency • Plan termination • Qualified domestic relations order • Small account distribution ($5,000 or less) • Permissible eligible automatic contribution arrangement (EACA) withdrawals Required minimum distributions apply under the rules of Internal Revenue Code Section 401(a)(9).
Forms, Approvals, and Corrections	• Determination letters from the IRS are not available, but a private letter ruling can be requested for IRS approval that the plan language meets applicable requirements. • 457(b) plans generally may not use the IRS Voluntary Correction Program under EPCRS (Rev. Proc. 2019-19), but may request a voluntary closing agreement. There is also a special statutory period to correct a plan failure – by the 1st day of the plan year beginning more than 180 days after notification of a failure by the IRS. • Excess elective deferrals may be corrected by distributing the excess (plus allocable income) as soon as administratively practicable after the plan determines that the amount is an excess deferral.

Useful IRS Publications	• Comparison of Tax Exempt 457(b) Plans and Governmental 457(b) Plans: https://www.irs.gov/retirement-plans/comparison-of-tax-exempt-457b-plans-and-governmental-457b-plans
	• Government Retirement Plans Toolkit: https://www.irs.gov/government-entities/federal-state-local-governments/government-retirement-plans-toolkit
	• Establishing a 457(b) Plan:
	  ◦ Revenue Procedure 2004-56, 457(b) Model Language: https://www.irs.gov/irb/2004-35_IRB#RP-2004-56
	  ◦ Revenue Ruling 2004-57, Union-administered 457 Plan: https://www.irs.gov/irb/2004-24_IRB#RR-2004-57
	• Operating and Maintaining a 457(b) Plan:
	  ◦ 457 Final Regulations (T.D. 9075), July 11, 2003: https://www.irs.gov/irb/2003-39_IRB
	  ◦ Notice 2003-20, 457(b) Reporting Requirements: https://www.irs.gov/pub/irs-drop/n-03-20.pdf
	• Correcting a 457(b) Plan:
	  ◦ 457(b) Submissions to Voluntary Compliance: https://www.irs.gov/retirement-plans/457b-plan-submissions-to-voluntary-compliance
	  ◦ Correcting Plan Errors: https://www.irs.gov/retirement-plans/correcting-plan-errors

IRS Provides Additional Guidance on Terminating 403(b) Plans

In November 2020, in response to direction under the *Setting Every Community Up for Retirement Enhancement Act of 2019* (SECURE Act), the IRS released Revenue Ruling 2020-23, which provides clarity on how 403(b)(7) custodial accounts can meet the distribution requirements upon a plan termination. The Revenue Ruling provides that such plans can meet these requirements by distributing fully paid individual custodial accounts (ICAs) in kind to members or beneficiaries.

Background

In order to terminate a 403(b) plan, members and beneficiaries must receive a distribution of their accumulated benefits under the plan. This can be more complex for 403(b) plans than other types of retirement savings vehicles, as 403(b) plans are generally invested in annuity contracts or custodial accounts holding mutual funds, which limits the control plan sponsors have with regard to distributions.

Revenue Ruling 2020-23 piggybacked on the authority provided in Revenue Ruling 2011-7, which provided that 403(b) plans can use fully paid individual annuity contracts or individual certificates evidencing fully paid benefits under a group annuity contract to meet distribution requirements upon termination. In such case, the distribution of an annuity is not a taxable event. Instead, the distribution from the annuity to the member is taxable. However, Revenue Ruling 2011-7 did not clarify the procedure for distributions for custodial accounts under 403(b)(7), prompting the direction in the SECURE Act to provide guidance on 403(b)(7) plan terminations.

2020 IRS Guidance on Custodial Accounts

Revenue Ruling 2020-23 provides that ICAs may be distributed to members and beneficiaries in kind upon the termination of a 403(b) plan - effective retroactively for tax years beginning on or after December 31, 2008. This removes the requirement that there be a cash distribution for custodial accounts, and allows members and beneficiaries to retain the benefit of tax deferral until they receive payments from the ICA. Revenue Ruling 2020-23 provides that: 1) the Section 403(b)(7) status of the distributed custodial account generally is maintained if the custodial account thereafter adheres to the requirements of Section 403(b) that are in effect at the time of the distribution of the account; and 2) a custodial account is not considered distributed to the member or beneficiary if the employer retains any material rights under the account. With regard to process, if the custodial accounts maintained under the plan are under individual agreements, distribution of the ICA in kind is sufficient. However, if the plan maintains custodial accounts under a group agreement, the plan must furnish a document to members and beneficiaries that evidences the ICA. This would include the nonforfeitable value of the member's or beneficiary's interest, as well as applicable rights and responsibilities.

Changes to Default Taxation of Periodic Pension Payments Held Until After 2021

The default withholding rule for periodic pension payments has long been determined by treating the retiree as a married individual claiming three withholding allowances. Although changes are likely on the horizon, this default withholding rule will remain as such through 2021.

In 2017, the *Tax Cuts and Jobs Act* (TCJA) amended the default rule for taxation of periodic pension payments to be prescribed by the Secretary of Treasury rather than treating the taxpayer as a married individual with three exemptions. In July 2020, the IRS released a draft of a redesigned Form W-4P, which is used by taxpayers who are receiving pension or annuity payments to determine the correct amount of federal income tax to withhold. The intent was to align provisions and process between Form W-4P and Form W-4. The draft form proposed "single with no adjustments" as the new default withholding rate for periodic pension payments, which the IRS originally intended to implement on payments made after December 31, 2020.

However, on September 28, 2020, the IRS announced that these changes will be delayed and the 2021 Form W-4P will mirror the 2020 Form. This delay allows plan sponsors the time they need to prepare to implement

changes to the default withholding rate and to communicate those changes to members. In the meantime, members will also be able to continue using the W-4 estimator to determine their pension withholding rate.

Tri-Agency Guidance Addresses Coverage of COVID-19 Preventive Services

On October 28, 2020, the Departments of Health and Human Services, Labor, and the Treasury (collectively, the Departments) released an interim final rule (IFR) with request for comment that, among other things, amends current regulations regarding coverage of preventive health services to implement the requirement under the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) that group health plans and health insurance issuers provide "rapid coverage" of services and vaccines related to the prevention of COVID-19. The IFR clarifies the meaning of a "qualifying coronavirus preventive service," explains which related items and services must also be covered, imposes an out-of-network coverage requirement, and codifies the rapid implementation timeline provided under the CARES Act.

Qualifying Coronavirus Preventive Service

A "qualifying coronavirus preventive service" is defined under the CARES Act and generally aligns with the definition of preventive services under the Affordable Care Act (ACA). However, ACA regulations specify that only immunizations recommended for "routine use" (those listed on the Center for Disease Control's (CDC's) Immunization Schedules) be covered without cost sharing.

The definition of "qualifying coronavirus preventive service" under the IFR is consistent with the definition in the CARES Act except that, unlike other preventive service immunizations, "qualifying coronavirus preventive services" are not limited to COVID-19 immunizations that are recommended for "routine use." Accordingly, plans and issuers must cover such services without cost sharing even if not listed for routine use on the CDC's Immunization Schedules.

Related Items and Services

Under the IFR (and ACA rules, generally), group health plans and health insurance issuers must cover, without cost sharing, items and services that are integral to the furnishing of the recommended preventive service, regardless of whether the items or services are billed separately. The Departments note that since a medical professional will generally need to administer a recommended immunization, plans and insurers must cover, without cost sharing, the immunization *and* its administration, regardless of how it is billed or whether it requires multiple doses. The Departments clarify that this is so even in instances where a third party (such as the federal government) pays for the actual immunization.

Out-of-Network Coverage

Under the ACA preventive services requirements, plans and insurers are generally not required to cover preventive services out-of-network or to waive out-of-network cost sharing if the plan's in-network providers offer such service. By contrast, the IFR requires that plans and insurers cover, without cost sharing, a qualifying coronavirus preventive service, regardless of whether an in-network or out-of-network provider delivers the service. The Departments reason that newly developed coronavirus-related preventive services may not be widely available, so this requirement is designed to "ensure full access to and the widespread use of qualifying coronavirus preventive services."

To ensure that the benefit is "meaningful," the Departments specify that plans and insurers must reimburse out-of-network providers "in an amount that is reasonable, as determined in comparison to prevailing market rates for such service." For instance, the Departments consider the amount that would be paid under Medicare for the item or service to be reasonable.

Rapid Coverage

Under the ACA, the requirement that group health plans and health insurers cover certain preventive services, without cost-sharing, generally does not apply until the plan year that begins one year after the designation/recommendation of the preventive services. However, under the CARES Act, group health plans and health

insurance issuers are required to cover, without cost sharing, qualifying coronavirus preventive services no later than 15 business days after the designation as a preventive service. The IFR codifies this timing requirement.

Sunset

Certain provisions of the IFR will sunset at the end of the COVID-19 public health emergency. Specifically, the definition of qualifying coronavirus preventive services (covering immunizations not yet approved for routine use), the requirement to provide out-of-network qualifying coronavirus preventive services without cost share, and the 15-day rapid coverage timeline will not apply to qualifying coronavirus preventive services furnished on or after the expiration of the public health emergency.

The regulations were effective on November 2, 2020, and comments were due by January 4, 2021. It is possible that there will be some additional clarifying guidance on the COVID-19 vaccine requirement following the Departments' review of comments submitted by stakeholders.

Health Plan and Insurer Price Transparency Regulations

On October 29, 2020, the Departments of Health and Human Services, Labor, and the Treasury (collectively, the Departments) issued final regulations on price transparency requirements (final regulations). The final regulations arise out of executive order No. 13877, "Improving Price and Quality Transparency in American Healthcare to Put Patients First," and the Departments point to specific provisions of the Affordable Care Act (ACA) as the legal basis for the rules.

The final regulations contain two requirements related to price transparency. Under the first requirement, group health plans and health insurance issuers must make cost-sharing information available to participants, beneficiaries, or enrollees, upon request, using an internet-based self-service tool (or in paper form, if requested). Under the second requirement, plans and issuers will be required to publicly disclose, using machine-readable files, in-network negotiated rates with providers, out-of-network allowable rates, and negotiated prescription drug rates and historical net prices for all covered drugs. Each provision is briefly discussed below.

Disclosure of Cost-Sharing Information to Participants, Beneficiaries, and Enrollees

The final regulations require that plans and issuers disclose certain cost-sharing information for a particular health care item or service to participants, beneficiaries, and enrollees. The Departments state that the rules are intended to enable participants, beneficiaries, and enrollees to obtain an estimate of their potential cost-sharing liability for covered items and services they might receive from a particular health care provider.

Cost-sharing information must be disclosed upon request in two ways: 1) through an internet-based self-service tool; and 2) in paper form, if requested. Cost-sharing information must also be disclosed in a manner that the average participant, beneficiary, or enrollee can understand. The Departments list seven "content elements" that must be provided as part of the cost-sharing disclosure, including:

- Estimated cost-sharing liability for a requested covered item or service;
- Accumulated amounts incurred to date;
- In-network rates, including the negotiated rate and underlying fee schedule rate, if applicable;
- Out-of-network allowed amount for the requested covered item or service;
- A list of those covered items and services for which cost-sharing information is being disclosed for items or services subject to a bundled payment arrangement;
- A notification, whenever applicable, informing the individual that a specific covered item or service for which the individual requests cost-sharing information may be subject to a prerequisite for coverage; and
- A notice that explains certain cost share information disclosed in the self-service tool.

Public Disclosure of In-Network Rates, Historical Allowed Amount Data, and Prescription Drug Pricing Information for Covered Items and Services from In- and Out-of-Network Providers

The final regulations also require plans and issuers to publicly post three machine-readable files, with specific

content elements for each file: 1) negotiated rates with in-network providers; 2) data outlining the different billed charges and allowed amounts a plan or issuer has paid for covered items or services, including prescription drugs, furnished by out-of-network providers; and 3) negotiated rates and historical net prices for prescription drugs furnished by in-network providers.

The Departments posit that publicly available negotiated rate information and historical allowed amount data for covered items and services provided by out-of-network providers will "empower consumers to make informed decisions about their health care, spur competition in health care markets, and slow or potentially reverse the rising cost of health care items and services."

The machine-readable files must be made publicly available and accessible to any person free of charge and without conditions, such as the creation of a user account or the submission of personally identifiable information. The final regulations also specify that plans and issuers must update all three machine-readable files monthly.

Applicability and Timing

The final regulations apply to group health plans and health insurance issuers offering non-grandfathered group or individual insurance coverage (including "grandmothered" plans). The final regulations do not apply to grandfathered health plans; health reimbursement arrangements or other account-based group health plans; excepted benefits; short-term, limited duration insurance; and expatriate health plans.

The rules begin to take effect in January 2022, but will not take full effect until 2024. Specifically, the requirement to publish the machine-readable files will become effective for plan or policy years beginning on or after January 1, 2022. Additionally, the cost-sharing tool for over 500 specified services must be made available for plan years beginning on or after January 1, 2023, and for all services for plan years beginning on or after January 1, 2024.

Proposed 2022 Notice of Benefit and Payment Parameters

On November 25, 2020, the Centers for Medicare and Medicaid Services (CMS) released the 2022 Notice of Benefit and Payment Parameters (NBPP) proposed rule. As is typical with the annual NBPP, CMS proposes a number of changes for the 2022 plan year, including for exchanges and health insurance coverage. This summary addresses changes related to special enrollment periods and the maximum annual limitation on cost sharing.

Special Enrollment Periods

In the NBPP, CMS proposes several amendments pertaining to special enrollment periods (SEP) for the individual market, including flexibility for individuals who did not receive timely notice of an SEP triggering event and SEP eligibility due to the cessation of employer contributions for continuation coverage under the *Consolidated Omnibus Budget and Reconciliation Act of 1985* (COBRA).

CMS proposes allowing an individual, enrollee, or dependent who did not receive timely notice of an SEP triggering event (and who was otherwise reasonably unaware that a triggering event occurred) to select an individual market plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. The proposal would also allow such persons to choose the earliest effective date that would have been available if he or she had received timely notice of the triggering event. CMS notes that this change would help individuals who may not be aware of an event that triggers an SEP until after the triggering event has occurred. CMS proposes that these SEP rules would apply to issuers of non-grandfathered coverage in the individual market, both on- and off-exchange.

CMS also proposes to designate the cessation of employer contributions for COBRA continuation coverage as a triggering event for SEP eligibility for the individual market. This proposed change would apply in situations where a former employer has opted to pay all or a part of their former employee's premium for part or all of the COBRA coverage period. In such a situation, the

triggering event would occur as of the last day of the period for which COBRA continuation coverage was paid for, in whole or in part, by the employer. CMS notes that this policy is currently in place on the exchanges using the federal platform; however, loss of coverage based on complete cessation of employer contributions for COBRA coverage might not be treated as a triggering event by issuers of individual coverage off-exchange or by state exchanges. In addition to this proposal, the Department of Health and Human Services (HHS) is also considering addressing situations in which an employer reduces, but does not completely cease, its contributions for COBRA continuation coverage. CMS requested comments on such a proposal.

Premium Adjustment Percentage and Maximum Annual Limitation on Cost-Sharing

To set cost-sharing limits, the ACA directs the Secretary of HHS to determine an annual premium adjustment percentage, a measure of premium growth that is used to set the rate of increase for three parameters: 1) the maximum annual limitation on cost sharing; 2) the required contribution percentage used to determine whether an individual can afford minimum essential coverage (MEC); and 3) the employer shared responsibility payment amounts.

CMS proposes the 2022 benefit year annual premium adjustment percentage using the most recent estimates and projections of per enrollee premiums for private health insurance (excluding Medigap and property and casualty insurance) from the National Health Expenditure Accounts (NHEA), which are calculated by CMS. For the 2022 benefit year, the premium adjustment percentage will represent the percentage by which this measure for 2021 exceeds that for 2013. For the 2023 benefit year and beyond, CMS proposes to release the annual updates to the premium adjustment percentage and maximum annual limitation on cost sharing guidance by January of the year preceding the applicable benefit year unless HHS is changing the methodology for calculating the parameters, in which case, CMS would do so through notice-and-comment rulemaking.

The proposed maximum out-of-pocket limit on cost-sharing for 2022 is $9,100 for self-only coverage and $18,200 for other than self-only coverage. This is a 6.4% increase from the 2021 parameters of $8,550 for self-only coverage and $17,100 for other than self-only coverage.

Comments on these proposals were due by December 30, 2020. On January 19th, the Trump Administration finalized parts of the NBPP proposed rule. The remaining provisions of the proposed rule, which include those discussed here, will be finalized by the new Biden Administration.

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