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INSIGHT

IN THIS ISSUE

1 Legislative Update

2 ESG Update

2 Basics on Additional Service Credits for Governmental Pension Plans Under IRC 415(n)

3 *White v. United Airlines, Inc.* Fuels Split on Military Leave

4 Legal Challenge to Minnesota County Deferred Compensation Plan Administration

4 New COBRA Subsidies Under the American Rescue Plan Act

5 New FSA Guidance

6 FAQs About FFCRA and CARES Act Implementation Part 44

7 Surprise Billing Provisions of the Consolidated Appropriations Act

Legislative Update

American Rescue Plan Act

On March 11, 2021, President Biden signed into law another COVID relief package—the *American Rescue Plan Act* (H.R. 1319, the Act or ARPA).

In addition to the health and retirement provisions described below, the legislation includes $360 billion in aid to state and local governments. This aid comes with a specific limitation stating, “No State or territory may use funds made available under this section for deposit into any pension fund.” This provision was included at the behest of certain conservative lawmakers who were concerned about the potential of federal dollars being used to support underfunded pensions or those they deemed to be “mismanaged.” In addition, Democrats included their own limitation on the use of federal funds: monies could not be used to offset state and local tax cuts.

Concerning health and retirement plan relief, the Act contains:

- 100% COBRA subsidies through September 30, 2021;
- Enhanced ACA premium tax subsidies through December 31, 2022; and
- Significant single-employer and multiemployer pension funding provisions.

Although not applicable to governmental plans, the changes to the funding rules for single-employer and multiemployer pension plans, along with significant financial assistance to deeply underfunded multiemployer pension plans, indicate an awareness of the struggles being faced by defined benefit plans. The Act also increases the premiums payable to the Pension Benefit Guaranty Corporation (PBGC) by multiemployer plans effective for plan years beginning after 2030.

Under the Act, the PBGC will provide special financial assistance to highly distressed multiemployer pension plans that satisfy one or more of the following criteria:

- In critical and declining status for any plan year from 2020 through 2022, generally indicating that the plan is expected to exhaust its assets in 20 years or less;
- Has previously reduced benefits under the provisions of the Multiemployer Pension Reform Act of 2014 (MPRA);
- In critical status for any plan year from 2020 through 2022, with a ratio of assets to liabilities (determined on a very conservative basis) of 40% or less, and a ratio of active to inactive participants of less than 2 to 3; or
- Became insolvent after December 14, 2014, but is not terminated (i.e., fully frozen).

Special financial assistance is paid to plans as single lump sums, with the amounts determined such that the plans are

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projected to remain solvent through 2051. The special financial assistance is supported by the general fund of the U.S. Treasury and will be paid through a new eighth fund within the PBGC. This differs from the existing multiemployer financial assistance provided by the PBGC, which is entirely supported by premiums paid by the plans themselves. In contrast with the financial assistance that the PBGC pays to insolvent multiemployer plans under current law, the special financial assistance under the Act is not subject to any repayment provisions.

The Act provides that any plan receiving special financial assistance must reinstate any benefits that were reduced under the benefit suspension provisions of MPRA. This reinstatement applies prospectively, and also includes back payments for previously suspended benefits.

Plans must segregate the special financial assistance received under the Act from other plan assets and may only invest the financial assistance in investment grade bonds unless the PBGC permits other investments. Subject to certain limitations, the PBGC may impose conditions on plans that receive financial assistance, and such plans are deemed to be in critical status through the 2051 plan year. The financial assistance provided by the Act is disregarded when determining plans' minimum funding requirements.

Administration News

- On January 29, 2021, President Biden issued an executive order to reopen an enrollment period for the federal *Affordable Care Act* (ACA) exchange in an effort to help Americans who have lost health insurance coverage during the pandemic. The federal exchange will be open for enrollment from February 15, 2021 through May 15, 2021.
- On March 10, 2021, the Department of Labor announced it will not enforce Trump Administration rules on ESG investing (see more information in the following article) and proxy voting.

ESG Update

In the first weeks of the Biden Administration, the Department of Labor (DOL) announced it will not enforce the Trump Administration's Environmental, Social, and Governance (ESG) rule that took effect on January 12, 2021. This rule requires fiduciaries to evaluate investments based on pecuniary factors, but, if all things are equal between investments, fiduciaries may use non-pecuniary factors as tie-breakers, such as socially conscious investing considerations.

The Trump Administration had considered doing away with the longstanding "all things being equal" test, but instead kept it in place. Notably, the DOL under the Trump Administration remained skeptical that two investments would ever be truly equal based on pecuniary factors. The final rule removed references to ESG factors, but made the default investment standard tougher.

On January 20, 2021, President Biden issued an executive order on Protecting Public Health and the Environment and Restoring Science to Tackle the Climate Crisis, which directed the DOL to review the ESG Rule. There is renewed interest in ESG investing, particularly by the new DOL Secretary Marty Walsh, who noted in his confirmation hearing that he is "especially concerned that recent rules could make it harder for plans to make investment decisions based on ESG factors, even when those factors are related to the economic wellbeing of plans and their participants." Many observers believe that the DOL under Biden will take a permissive approach to ESG investing, potentially defining socially conscious investment factors as material if they impact risk or returns.

Although the DOL ESG rule does not apply to public pension plans, the topic is equally as relevant in the public plan arena. Much of institutional ESG assets are held by public plans that are considering if and how to approach ESG factors. According to the Center for Retirement Research, as many as two-thirds of the public plans studied have either a social investing state mandate or an ESG policy. Actions taken by the DOL could indirectly impact public plans by potentially validating or constraining ESG investing in the private sector.

Basics on Additional Service Credits for Governmental Pension Plans Under IRC 415(n)

Many public pension plans allow participants the opportunity to purchase permissive service credit in order to receive credit for prior service or, in some cases, merely to increase their benefit under the plan. This provides government workers some flexibility of employment while allowing them the opportunity to remain in a defined benefit plan.

What types of service credit may be purchased?

A member may have permissive or nonqualified service credit under Internal Revenue Code (IRC) Section 415(n). Permissive service credit is defined as service credit that is

recognized by a governmental plan for calculating a participant's benefit that the participant does not already have credited under the plan, and may include credit for periods where no service is performed.

The participant must: 1) make a voluntary additional contribution to the plan to fund the increased benefit (the contribution cannot exceed the amount necessary to fund the benefit); and 2) this contribution is in addition to regular employee contributions.

Nonqualified service credit is generally any permissive service credit other than service as an employee of the federal government, state, political subdivision or agency or instrumentality thereof; service as an employee of certain educational organizations described in Code Section 170(b)(l)(A)(ii); military service or service as an employee of an association. Code Section 415(n)(3)(C) further provides that in the case of service described in (i), (ii), or (iii), such service will be nonqualified service if recognizing such service would cause a participant to receive a retirement benefit for the same service under more than one plan.

Are there limits on the amount of service credit that may be purchased?

There is no limit on the amount of permissive service credit that may be purchased, but the amount of nonqualified service purchased by participants must be limited. In order to satisfy Code Section 415(n), a plan must: 1) limit total nonqualified service purchases to five years or less; and 2) not permit such purchase until a participant has five years of service in the plan.

How are the Code Section 415 limits applied after a purchase of service credit?

Where a participant makes a purchase of service credit, Code Section 415 applies by either testing: 1) the participant's accrued benefit under Code Section 415(b); or 2) the participant contributions made to purchase the service credit under Code Section 415(c). The choice of applicable limit can be applied on an individual participant basis; it need not be applied plan-wide.

White v. United Airlines, Inc. Fuels Split on Military Leave

In February 2021, the United States Court of Appeals for the Seventh Circuit breathed life back into *White v. United Airlines, Inc.,*[1] allowing the proposed class action challenging employer requirements under the *Uniformed Services Employment and Reemployment Act* (USERRA) to move forward.

In *White*, Plaintiffs claim their employer, United Airlines, did not properly compensate employees taking short-term military leave, thus violating USERRA. Specifically, the putative class in *White* asserts that the Defendant violated USERRA by failing to offer them the same "rights and benefits" granted for other short-term leave (i.e., paid leave and profit-sharing credit while on short-term military leave). The Defendant argues that private sector employers are not obligated to provide paid military leave, and further claimed that offering other types of paid leave (such as sick time and leave for jury duty) does not obligate the company to offer paid military leave.

The District Court granted the Defendant's motion to dismiss, stating, "It is contrary to the express language of the statute to hold that a business is required to pay a reservist wages for time not worked." However, the Seventh Circuit found that USERRA mandates that employees on military leave receive the same "rights and benefits" as similarly situated non-military employees, including paid leave. Therefore, the Seventh Circuit found the District Court erred in dismissing the case as a matter of law, and the case was reversed and remanded.

A number of courts throughout the country have addressed this issue, but *White* is the first appellate court decision. In 2019, the United States District Court of the Eastern District of Pennsylvania similarly held in *Scanlan v. American Airlines Group*[2] that a putative class of airline pilots could pursue a claim against American Airlines for violating USERRA by not paying employees on short-term military leave. However, in 2020, the same District Court reversed course in *Travers v. FedEx Corporation*,[3] dismissing the proposed class action and holding that "Congress's protection of 'rights and benefits' for military reservists unambiguously excludes paid military leave." The plaintiffs

[1] *987 F.3d 616 (7th Cir. 2021).*
[2] *384 F. Supp. 3d 520 (E.D. Pa. 2019).*
[3] *473 F. Supp. 3d 421 (E.D. Pa. 2020).*

have appealed. A similar case has been filed against Southwest Airlines in California's Northern District.

The fate of *White* is unclear. In particular, employers in the Seventh Circuit (including those in Wisconsin, Illinois, and Indiana) should remain watchful of this case. However, the issue is worth watching by employers across the country, as it remains an unsettled area of law.

Legal Challenge to Minnesota County Deferred Compensation Plan Administration

A state system recently saw a proposed class action lawsuit filed where participants allege a failure to make required employer contributions to the Minnesota Deferred Compensation Plan, a defined contribution plan.[4] The putative class includes both current and former employees of Ramsey County (totaling as many as 4,000 individuals). The lawsuit names Ramsey County, the Minnesota State Retirement System (Retirement System) and the Retirement System's Executive Director as defendants in the case.

The underlying allegation is that, instead of directly depositing pre-tax matching contributions to the participants' deferred compensation accounts, the County instead diverted the funds to employee paychecks causing them to be taxed as income.

Specifically, the Plaintiffs allege that the practice of remitting matching funds as wages, for many years, rather than as plan contributions, was improper, leading Plaintiffs to miss out on hundreds of dollars of annual investment opportunities—roughly $35 per month in matching contributions for non-union employees and an amount determined by the applicable collective bargaining agreement for union employees—and causing millions of dollars in investment losses over the last decade. According to the Plaintiffs, this practice constitutes breaches of fiduciary duty and contract, meriting restitution equivalent to lost revenue for impacted Ramsey County employees.

Ramsey County and the Retirement System have yet to comment on the case.

New COBRA Subsidies Under the American Rescue Plan Act

On March 11, 2021, President Biden signed the *American Rescue Plan Act* (the Act or ARPA) into law. The Act included a temporary 100% subsidy for continuation coverage under the *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA), which is intended to assist those who have experienced either job loss or a reduction in work hours during the ongoing COVID-19 pandemic.

Background

COBRA generally allows certain eligible employees, along with their spouses and children, continued access to the employer's health coverage after the individual has experienced a triggering event, such as job loss or a reduction in work hours. However, these individuals typically are required to pay for COBRA premiums out of pocket (including a 2% administrative fee).

100% COBRA Subsidy

Under the Act, the employers must provide a 100% subsidy (including the 2% administrative fee) for certain COBRA qualified beneficiaries. The subsidy is available for coverage periods between April 1, 2021 and September 30, 2021. Eligible individuals will not have to pay any out-of-pocket expenses for COBRA premiums during the applicable period. Rather, the premium is "advanced" by the employer (or plan or insurer in some cases), and is then reimbursed by the Federal government in the form of a refundable tax credit. The subsidy will end earlier, however, if the qualified beneficiary's maximum COBRA coverage period ends, or if the individual becomes eligible for either: 1) other group health plan coverage; or 2) Medicare.

Eligible Individuals

Under the Act, an "assistance eligible individual" is any qualified beneficiary who: 1) is eligible for COBRA continuation coverage by reason of a termination of employment (except for voluntary terminations) or a reduction in work hours; and 2) elects COBRA continuation coverage. The subsidy is also available to spouses and children. Additionally, ARPA provides another election

[4] *Allison Schaber v. Ramsey County, Minnesota State Retirement System, Erin Leonard*, 62-Cv-21-1228.

opportunity for the subsided coverage for individuals who: 1) do not have an election of COBRA continuation coverage in effect on April 1, 2021, but would otherwise be an "assistance eligible individual" if such election were in effect; or 2) the individual elected COBRA continuation coverage and discontinued the coverage before April 1, 2021 (e.g., due to non-payment of premiums).

The Tax Credit

The entity to which the premiums were due can receive a refund of the subsidized amount from the Federal government in the form of a refundable tax credit against Medicare hospital insurance (HI) taxes. In the case of an insured or self-insured plan subject to COBRA under the Code, the *Employee Retirement Income Security Act* (ERISA), or the *Public Health Service Act*, the employer claims the tax credit. In the case of a multiemployer plan, the plan claims the tax credit, and in the case of an insured plan subject to state continuation coverage, the insurer claims the tax credit.

Notice Requirements

The Act further requires that employers update required COBRA notices, so that the notice outlines the availability of the subsidy under the Act and the new election period for certain individuals. For individuals entitled to elect COBRA prior to April 1, 2021, the notice is due by May 31, 2021. For all other individuals, the regular COBRA election notice deadlines appear to apply. Employers must also provide a notice of the end of the premium subsidy between 15-45 days before the end of the subsidy (except in certain circumstances). The Department of Labor (DOL) issued model notices on April 7, 2021.[5]

New FSA Guidance

Background

Recent legislation and guidance have made numerous changes to flexible spending accounts (FSAs) and generally give employers greater flexibility to provide more advantageous FSA benefits to their employees. These changes are briefly described below:

Consolidated Appropriations Act and IRS Notice 2021-15

On December 27, 2020, President Trump signed into law the *Consolidated Appropriations Act, 2021* (the Act), and on February 18, 2021, the Internal Revenue Service (IRS) released Notice 2021-15 (the Notice).

The Act and the Notice provide the following:

- *Carryovers* – Employers can permit participants to carry over unlimited amounts of unused health and dependent care FSA funds from a plan year ending in 2020 to 2021 and a plan year ending in 2021 to 2022. Employers can limit the carryover to an amount less than the full unused balance and can set a deadline prior to the end of the plan year by which employees must use any amounts carried over. The IRS also provided rules regarding how to preserve health savings account (HSA) eligibility for employees with a general-purpose health FSA who elect to contribute to an HSA in the following plan year.
- *Extended Grace Periods* – Employers can adopt an extended grace period of up to 12 months for plan years ending in 2020 and 2021. Employers can adopt a grace period of less than 12 months at their discretion. The IRS also provided rules regarding how to preserve HSA eligibility for employees with funds remaining at the end of the plan year in a general-purpose health FSA who elect to contribute to an HSA in the following plan year.
- *Post-Termination FSAs* – Employers can permit employees who ceased health FSA participation during calendar year 2020 or 2021 to continue to receive reimbursements through the end of the plan year (and grace period). Employers can limit the amount of reimbursements available to the amount of salary reduction contributions the employee made prior to termination of participation.
- *Dependent Care FSA Age Increase* – For dependent care FSAs with a plan year that had an open enrollment period on or before January 31, 2020, employers can permit participants to receive reimbursements for the entire plan year for a child who turned age 13 during the plan year. Further, if there is an unused balance at the end of the plan year, participants can receive reimbursements (up to the amount of the unused

[5] https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premium-subsidy

balance) in the subsequent plan year for a child who either: 1) turned age 13 in the prior plan year (until that child turns age 14); and/or 2) turns age 13 in the subsequent plan year.

- *Election Changes* – For plan years ending in 2021, employers can permit an employee to change his or her FSA election mid-plan year, regardless of the reason.
- *Plan Amendments* – Employers may generally amend their cafeteria plan retroactively to adopt these changes.

American Rescue Plan Act

On March 11, 2021, President Biden signed the *American Rescue Plan Act* (ARPA) into law. ARPA included a temporary increase in the exclusion for dependent care FSAs from $5,000 to $10,500 (and from $2,500 to $5,250 for married filing single). Further, an employer can retroactively adopt this increased limit amount, as long as the amendment is adopted no later than the last day of the plan year that the amendment is effective, and the plan is operated consistent with the terms of the amendment beginning on the effective date of the amendment and ending the date the amendment is adopted.

FAQs About FFCRA and CARES Act Implementation Part 44

On February 26, 2021, the Department of Labor, Health and Human Services and the Treasury (the Departments) issued frequently asked questions (FAQs) about the *Families First Coronavirus Response Act* (FFCRA) and the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) implementation. These FAQs address questions related to coverage of COVID-19 diagnostic testing, COVID-19 preventive services, summary of benefits and coverage notification, and excepted benefit status of employee assistance programs.

On March 18, 2020, FFCRA was enacted and requires group health plans and health insurance issuers to provide benefits related to COVID-19 diagnostic testing without cost-sharing (including deductibles, copayments, and coinsurance), prior authorization, or other medical management requirements. The CARES Act was enacted March 27, 2020 and amended FFCRA to include a broader range of COVID-19 diagnostic tests that must be covered without cost-sharing. The CARES Act also requires plans and issuers to reimburse providers of COVID-19 diagnostic testing at a negotiated rate or, in absence of a negotiated rate, at the cash price, which providers are required to list on their public website.

COVID-19 Testing

Under FFCRA, plans and issuers may not impose medical management on coverage of COVID-19 diagnostic testing. This means plans and issuers cannot require symptoms, prior exposure, or a medical screening as a requirement for coverage for the COVID-19 test.

When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an “individualized clinical assessment” and the test should be covered without cost sharing, prior authorization, or other medical management requirements. However, state and local public health authorities retain the right to direct providers to limit eligibility for testing based on clinical risk or other criteria to manage testing supplies and access to testing.

As noted above, plans and issuers must cover tests for asymptomatic individuals when the purpose is for a COVID-19 diagnosis, but continue to be exempt from covering testing for public health surveillance or employment purposes. Point-of-care tests (e.g., rapid tests) are not distinct from other kinds of COVID-19 tests and must be covered without cost-sharing.

FFCRA requires plans and issuers to cover items and services an individual receives during health care provider office visits (in-person and telehealth), urgent care center visits, or emergency room visits that result in the receipt or ordering of a COVID-19 test. Plans and issuers should maintain claims processing and other informational technology systems in ways that protect participants, beneficiaries, and enrollees from inappropriate cost sharing. Plans and issuers can share information about providers who adhere to best practice standards and have a negotiated rate for COVID-19 tests.

COVID-19 Preventive Services

The CARES Act requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage to cover any qualifying COVID-19 preventive services without cost-sharing. Qualifying preventive services include an item, service, or immunization intended

to prevent or mitigate COVID-19 that has an A or B rating from the U.S. Preventive Services Task Force (USPSTF), or an immunization that has a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Plans and issuers must provide coverage without cost sharing for all recommended vaccines beginning no later than 15 business days after USPSTF or ACIP makes the applicable recommendation. Plans and issuers must cover the vaccine administration fee regardless of the number of doses and how the administration is billed. This includes coverage of vaccine administration fees when the vaccine itself is paid for by a third party (e.g., the Federal government).

Plans and issuers must cover the COVID-19 vaccine without cost sharing regardless of priority of the individual. Providers have the right to decline to give a COVID-19 vaccine to patients based on prioritization, but it is not an adverse benefit determination made by the plan or issuer. The provider's decision is not subject to the internal claims and appeals and external review requirements.

Notice Requirements

Section 2715(d)(4) of the *Public Health Service Act* and final rules issued by the Departments regarding the summary of benefits and coverage (SBC) requires plans and issuers to provide a 60-day notice *prior to* modifying the terms of the plan or coverage that would affect the content of the SBC. The Departments will not take enforcement action when a plan makes modifications regarding COVID-19 preventive services without satisfying the advance notice requirement.

Excepted Benefits

Excepted benefits relevant to this FAQ are benefits that are generally not health coverage (including on-site medical clinics) and limited excepted benefits, such as employee assistance programs (EAP) that meet certain conditions. EAPs are excepted if they do not provide significant medical care and are not coordinated with benefits under another group health plan.

An employer may offer COVID-19 diagnosis and testing benefits under an EAP during a declared public health emergency or national emergency. Also, an employer may offer benefits for COVID-19 vaccines under an EAP that constitutes as an excepted benefit without being considered as providing significant benefits of medical care. There must be no cost sharing under EAP for benefits to constitute as excepted benefits and an EAP must also comply with other applicable requirements. Additionally, an employer may offer benefits for COVID-19 vaccines at an on-site medical clinic that constitutes an excepted benefit, and coverage of on-site medical clinics is an excepted benefit in all circumstances.

Surprise Billing Provisions of the Consolidated Appropriations Act

In the final days of 2020, Congress passed the *Consolidated Appropriations Act, 2021* (the Act or CAA). The Act contained a number of unexpected health-related protections making it the largest health care legislative package since the *Affordable Care Act* (ACA).

As part of the CAA, Congress addressed the long-debated issue of surprise balance bills by including the "No Surprises Act," a component of the CAA that contains plan, issuer, and provider obligations that work together to prevent patients from receiving unexpected balance bills.

The key provisions of the No Surprises Act include:

Emergency Services

The No Surprises Act addresses surprise balance billing in emergency situations by including provisions that will replace the ACA's emergency services regulatory scheme as of January 1, 2022.

Under the No Surprises Act, plans and issuers must cover emergency services without any prior authorization requirements and without imposing any restrictions on out-of-network emergency care that are greater than those imposed on in-network emergency care. Additionally, plans and issuers must cover out-of-network emergency services at in-network cost-sharing rates and such cost sharing must be applied to the patient's in-network deductible and out-of-pocket maximum.

Certain payment provisions, such as the "cost-sharing amount" or "qualifying payment amount" are defined within the statute, and further regulatory guidance on cost-share payment methodology is expected this summer.

Services Provided by Non-Network Providers at In-Network Facilities

The No Surprises Act also contains rules that apply to non-emergency situations where an individual receives care from an out-of-network provider at an in-network facility. In such situations, a plan or issuer must apply in-network cost sharing and such cost-sharing amounts must count towards the patient's in-network deductible and out-of-pocket maximum.

The payment terms that apply to out-of-network emergency services also apply to non-network providers at in-network facilities. In both instances, the plan or issuer must pay (or deny) the bill within 30 calendar days of transmission by the provider.

Notice and Consent Requirements

Under the No Surprises Act, out-of-network providers generally cannot bill an individual more than the cost-sharing amount. However, certain non-ancillary, out-of-network providers offering non-emergency services may provide written notice and receive signed consent from the individual to avoid being subject to the prohibition on balance billing. The written notice must contain specific information, such as an estimate of the charges and a list of network providers at the facility who are able to furnish the requested item or service. Ancillary services providers (such as those providing anesthesiology, pathology, radiology, and diagnostic services) are not able to utilize the notice and consent process to avoid the prohibition on balance billing.

Independent Dispute Resolution (IDR) Process

The No Surprises Act also includes a dispute resolution process by which a plan or issuer and an out-of-network provider can negotiate and/or arbitrate the payment amount for the furnished item or service. Once the provider or facility receives the initial payment (or denial), the parties can open a 30-day negotiation period to discuss the payment amount. If the parties cannot resolve a payment dispute within 30 days, either party can initiate a binding IDR process within 4 days of the end of the negotiation period.

Under the IDR process, each party must submit a final offer for consideration by a certified IDR entity. The parties may submit certain additional information for consideration by the certified IDR entity, such as the provider's level of training or the complexity of furnishing the item or service. However, the certified IDR entity cannot consider the usual and customary rate, the amount that otherwise would have been billed, or public payor amounts. Within 30 days after selection, the certified IDR entity must choose one of the parties' offers for the payment amount, and payment must be made to the provider within 30 days of the determination.

Timeline

The provisions under the No Surprises Act are generally effective for plan years beginning as of January 1, 2022.

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