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INSIGHT

IN THIS ISSUE

Pension Plans Legislative Update

Securing a Strong Retirement Act

On May 5, 2021, the House Ways and Means Committee unanimously approved the *Securing a Strong Retirement Act* (H.R. 2954, referred to as SECURE 2.0). The bill proposes a number of changes that would affect retirement plans.

Notably, SECURE 2.0 would incrementally increase the age for required minimum distributions (RMDs) through 2032. For members born prior to July 1, 1949, the age at which required minimum distributions are required to begin is generally age 70½. For members born after June 30, 1949, as provided by the 2019 SECURE Act, required minimum distributions generally must begin by age 72. SECURE 2.0 would increase the required minimum distributions age to 73 beginning in 2022, age 74 beginning in 2029, and age 75 beginning in 2032.[1] Further, the penalty for failing to make a RMD would be reduced to 25%, and if the mistake is corrected in a timely way, the penalty would be reduced further to 10%.

Under SECURE 2.0, participants in governmental 457(b) plans would be permitted to change their deferral rate any time before the compensation on which such deferral is based is available to them, eliminating the restriction that such election be in place by the first of the month.

Further, the bill would greatly expand the Internal Revenue Services' (IRS') self-correction process and make additional changes to permissible overpayment corrections for 401(a), 403(a), 403(b) and governmental plans (not including 457(b) plans). Specifically, it provides that a plan will not lose its tax favored status because it fails to recover an accidental benefit overpayment or amends the plan to permit the accidental overpayment. The bill also provides fiduciary relief for failure to make the plan whole.

The bill would also: require repayment of qualified birth or adoption payments within three years of the distribution to qualify as a rollover contribution; treat student loan payments as elective deferrals for the purposes of matching contributions; and allow 403(b) plans with custodial accounts to invest in collective investment trusts.

SECURE 2.0 moved swiftly through the Ways and Means Committee by being marked-up the same week it was introduced. However, the bill faces slower movement going forward. The House Education and Labor Committee has indicated it will assert jurisdiction over the bill, but has not given timing for taking the bill up. Until the bill passes the Education and Labor Committee, it will not head to the House floor for a vote.

Retirement Security & Savings Act

On May 20th, 2021, Senators Ben Cardin (D-MD) and Rob Portman (R-OH)

[1] A member's required beginning date remains April 1 of the calendar year following the later of the calendar year in which the member attains the applicable RMD age or retires.

reintroduced a revised version of their *Retirement Security & Savings Act* (S. 1770). More than half of the bill's provisions are identical or substantially similar to SECURE 2.0. The Senate Finance Committee, of which Senators Cardin and Portman are members, may hold a mark-up for this bill sometime in the fall.

Windfall Elimination Provision Update

Legislation has been introduced again this year in Congress to reform the Windfall Elimination Provision (WEP). Generally, the WEP is a modified benefit formula that reduces the Social Security benefits of certain retired or disabled workers who are also entitled to pension benefits based on earnings from jobs that were not covered by Social Security and thus not subject to the Social Security payroll tax.

The WEP currently affects nearly two million public sector employees (about 3% of all Social Security beneficiaries). It applies to federal employees who began their federal employment prior to 1983, as well as to state and local government employees covered by public sector defined benefit plans that did not pay into Social Security during their government employment. However, the WEP does not apply to public employees that paid Social Security payroll taxes while employed in the public sector.

On April 1, 2021, the House Ways & Means Committee Chairman Richard Neal (D-MA) reintroduced the *Public Servants Protection and Fairness Act* (H.R. 2337) to repeal and replace the WEP. This bill, which was previously introduced in 2019, seeks to provide relief to retired public employees that are Social Security beneficiaries and affected by the WEP, as well as create a new formula for future retirees called the Public Servant Protection (PSP) formula. As of June 15th, the bill had 160 additional co-sponsors.

The new formula proposed in the *Public Servants Protection and Fairness Act*, would allow future retirees to receive benefit amounts based on the proportion of their lifetime earnings covered by Social Security, while guaranteeing that individuals who would receive a higher benefit under the WEP formula would be able to keep that higher benefit. Current retirees affected by the WEP would receive an additional $150 per month, subject to the limitation that this additional payment cannot exceed the amount their benefits are reduced by the WEP. The Social Security Administration's Chief Actuary estimated that these changes would increase the Social Security program's benefit cost by $30.6 billion over ten years, but that the additional cost would be fully reimbursed by transfers from the General Fund of the Treasury.

In January 2021, Representative Rodney Davis (R-IL) introduced a separate bill, the *Social Security Fairness Act* (H.R. 82), which would fully repeal (and not replace) the WEP. The bill has 167 co-sponsors.

In April 2021, Senator Sherrod Brown (D-OH) introduced a Senate version of the *Social Security Fairness Act* (S. 1302), which has 31 co-sponsors. A version of the *Social Security Fairness Act* has been introduced in each Congress dating back to 2001.

To date, neither chamber has taken any action to move any of these bills forward.

California State Court Invalidates San Diego Pension Cuts

The California Superior Court recently invalidated the City of San Diego's Proposition B, which sought to shift city employees (with the exception of police) hired after June 2012 from a defined benefit plan to a defined contribution plan. In April 2021, the 90-day window to appeal the ruling expired, cementing Proposition B's fate.

In 2012, San Diego voters approved Proposition B by a wide margin making it the only city in California to eliminate pensions for most new employees. Instead of a defined benefit pension, city workers would receive access to a 401(k)-style plan. Union representatives filed suit to overturn the results of the 2012 Proposition B election. The lawsuit hinged on the mayor's failure to negotiate with labor leaders at the time the measure was added to the ballot and whether that failure constituted an unfair labor practice.

The Public Employment Relations Board agreed with union representatives that the measure was unlawful, but the California Fourth District Court of Appeal overturned the Board's ruling in 2017.[2] In 2018, the Supreme Court of California reversed the lower court's decision, finding that the mayor did have a duty to meet and confer with union representatives.[3] After the U.S. Supreme Court declined to take on the case,[4] it was remanded back to the Court of

[2] *Boling v. Pub. Empl. Rel. Bd.*, 216 Cal. Rptr. 3d 757 (Cal. App. 4th Dist. 2017), *rev'd*, 422 P.3d 552 (Cal. 2018).
[3] *Boling v. Pub. Empl. Rel. Bd.,* 422 P.3d 552 (Cal. 2018).
[4] *City of San Diego, Cal. v. Pub. Empl. Rel. Bd.*, 139 S. Ct. 1337 (2019).

Appeal, where the court ordered the city to compensate the employees for the difference in compensation caused by Proposition B.[5] The City Council then voted to seek the measure's invalidation in court, leading to the Superior Court ultimately ruling that the labor law violation invalidated Proposition B entirely.[6]

Now that the deadline for further appeals has passed, the city will negotiate with labor unions to determine how to implement the decision and the City Council will pass an ordinance to remove Proposition B from the City Charter. Workers hired since 2012 will likely have a choice between a pension that starts this year and a retroactive pension starting on the date they were hired. It seems that many workers may choose to opt-out of the retroactive pension, as they would need to immediately pay retroactive pension contributions back to their hire date.

Appeals Court Affirms CalSavers Not Preempted by ERISA

On May 6, 2021, the Ninth Circuit Court of Appeals affirmed a lower court's ruling that the CalSavers payroll deduction IRA program is not preempted by the *Employee Retirement Income Security Act of 1974* (ERISA).[7]

Under California law, certain employers that do not offer a retirement plan must automatically enroll their employees in a state-facilitated payroll deduction IRA called CalSavers. The law was originally passed in 2012, and CalSavers is being phased-in for employers in California.

The Howard Jarvis Taxpayers Association (HJTA) brought a lawsuit arguing that the California law mandating certain employers participate in CalSavers was preempted by ERISA. ERISA preempts state laws that "relate to" employee benefit plans, and there is case law finding that states cannot mandate that employers sponsor an ERISA-covered employee benefit plan or interfere with plan administration.

In 2019, a state court held that CalSavers is not an employee benefit plan and that "finding that ERISA preempts CalSavers would be out-of-step with the underlying purposes of" ERISA because CalSavers does not govern a central matter of an ERISA plan's administration or interfere with nationally uniform plan administration.

In its decision, the Ninth Circuit wrote, "CalSavers is not an ERISA plan because it is established and maintained by the State, not employers; it does not require employers to operate their own ERISA plans; and it does not have an impermissible reference to or connection with ERISA. Nor does CalSavers interfere with ERISA's core purposes."

The court denied HJTA's subsequent petition for rehearing.

California v. Texas: Supreme Court Rejects the Latest Challenge to the Affordable Care Act

On June 17, 2021, the Supreme Court rejected the third challenge to the constitutionality of the *Affordable Care Act* (ACA) to reach its docket in *California v. Texas*.[8]

Background

The plaintiffs, Republican states and two individual purchasers of unsubsidized marketplace coverage, challenged the ACA on grounds that the individual mandate is unconstitutional under the *Tax Cuts and Jobs Act of 2017*, which reduced the penalty for lack of minimum essential coverage to $0. The plaintiffs argued that the individual mandate could no longer function as a tax upon individuals who fail to obtain health insurance as the Internal Revenue Service was no longer raising revenue. The plaintiffs further argued that the individual mandate was so inextricably intertwined with other parts of the ACA that, if the individual mandate was found unconstitutional, the entirety of the ACA must be unconstitutional as well.

In 2018, the U.S. Northern District of Texas held the individual mandate unconstitutional and determined the entirety of the ACA must fall as well.[9] The U.S. Court of Appeals for the Fifth Circuit partially affirmed the decision and remanded the question of whether any parts of the ACA could be severable from the individual mandate.[10] The Supreme Court agreed to hear the case on issues concerning the plaintiffs' standing, the constitutionality of the individual mandate, and the severability of the

[5] *Boling v. Pub. Empl. Rel. Bd.*, 245 Cal. Rptr. 3d 78 (Cal. App. 4th Dist. 2019), *reh'g denied* (Apr. 9, 2019).
[6] *People of the State of California v. City of San Diego,* No. 37-2019-00051308-CU-MC-CTL (Cal. Super. Ct. Jan. 5, 2021).
[7] *Howard Jarvis Taxpayers Ass'n v. California Secure Choice Ret. Sav. Program*, 997 F.3d 848 (9th Cir. 2021).
[8] *California v. Texas*, 141 S. Ct. 2104 (2021).
[9] *Texas v. United States*, 352 F. Supp. 3d 665 (N.D. Tex. 2018).
[10] *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019).

remainder of the ACA if the individual mandate was affirmed to be unconstitutional.

On February 10, 2021, the Biden Administration, in a departure from the Trump Administration's position, voiced support for the constitutionality of the individual mandate and, in the circumstance the mandate is deemed unconstitutional, its view that the remainder of the ACA is severable and lawful.

The Decision

In a seven to two decision, the Supreme Court ruled that both the state and individual plaintiffs lacked Article III standing to challenge the ACA due to a lack of past or future injury fairly traceable to the $0 individual mandate penalty, and remanded the case with instructions for dismissal. The Court decided that the challenging states failed to establish that the $0 penalty is the impetus for their residents enrolling in beneficial health benefit programs that those individuals would allegedly forgo without the mandate. Additionally, the Court determined that the plaintiff states also failed to adequately present evidence establishing that the $0 penalty resulted in an injury via higher administrative costs associated with the reporting requirements for the individual mandate. The Court held that the plaintiff individuals lacked standing due to the unenforceability of the penalty for noncompliance with the individual mandate and that, even if the Court found the individual mandate unconstitutional, the individuals' alleged injury would not be redressed.

In the opinion written by Justice Breyer, the Court did not address the constitutionality of the individual mandate or the severability implications if this provision was found unconstitutional. Therefore, the Court's holding that the individual mandate is constitutional as a tax under Congress' tax and spending powers in *NFIB v. Sebelius* (2012) remains good law.[11]

TAKEAWAYS

- The ACA, while still politically controversial, remains constitutional and is settled law. Consumers have avoided major disruption in health care coverage under this case's outcome.
- Plans and issuers must continue to comply with the requirements under the ACA.
- The Biden Administration continues to support and further bolster the ACA, which will likely lead to additional reversals of policy that had been implemented under the previous presidential administration.
- As the Court did not issue a substantive decision on the constitutionality of the individual mandate or the severability of the ACA if a provision under the ACA is found to be unconstitutional, a potential challenge to the ACA could be brought again in the future. Notable, however, is that a conservative majority ruled to preserve the ACA, potentially indicating that future opponents may not have success in ACA legal challenges.

Tri-Agencies Request Information on Consolidated Appropriations Act Prescription Drug Reporting Requirement

On June 21, 2021, the Departments of Labor, Health and Human Services, and the U.S. Treasury (the Departments or Tri-Agencies) and the Office of Personnel Management issued a request for information (RFI) regarding the pharmacy benefits and prescription drug cost reporting requirement (Rx Reporting) enacted by the *Consolidated Appropriations Act, 2021* (CAA). The Departments are seeking public comment on the general implementation, definitions, reporting entities, information required to be reported, coordination with other reporting requirements, public reports, and regulatory impact analysis to inform future rulemaking.

Comments on the RFI were due on July 23, 2021. The CAA mandates the Rx Reporting be submitted by plans and issuers by December 27, 2021 and by June 1st, subsequently.

The CAA Prescription Drug Reporting

The CAA requires group health plans and health insurance issuers to annually report specific information concerning pharmacy benefits and prescription drug costs that the Departments will utilize to issue a biannual public report.[12]

[11] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).
[12] 42 U.S.C. § 300gg-120.

The CAA requires reporting the following information:

- The number of participants and beneficiaries, the plan's annual beginning and end dates, and the states in which the plan is offered;
- The 50 brand prescription drugs most frequently dispensed and the total number of paid claims for each drug;
- The 50 costliest prescription drugs by total annual spending and the amount spent for each drug;
- The 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year and, for each drug, the change in amounts expended;
- Total health care spending by the plan, broken down by certain types of costs, such as prescription drug costs and other medical costs; and
- Information on plan premiums, including the impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan.

Based on the information reported, the Departments will analyze prescription drug reimbursement, pricing trends, and the impact of such drug costs on premiums in the aggregate and post a public report. The public report will not reveal specific plans' information or any confidential or trade secret data.

RFI Takeaways

Specifically, the Departments requested comments on a few key areas:

- The amount of time plans and issuers need to adequately prepare and submit the information to the Departments, and potential challenges with complying with reporting;
- What tools/systems the Departments should consider for submission of the Rx Reporting;
- Whether any state law exists with similar reporting requirements;
- Whether, or how, mandated disclosures overlap with other transparency requirements;
- Whether any other reporting requirements applicable to plans or issuers could be combined with the Rx Reporting;
- How price concessions or rebates directly sent to participants or beneficiaries should be treated;
- How direct payments from plans, issuers, or pharmacy benefit managers to drug manufacturers should be treated, if such payments exist;
- How multiple plans and coverage options could provide the required data in the aggregate, rather than each plan or coverage option to individually report its data;
- The extent to which plans and insurers will need to utilize third party administrators, pharmacy benefit managers, and other service providers when complying with the CAA;
- How information regarding rebates, fees, and other remuneration should be collected; and
- Considerations in defining what constitutes a "pharmacy", "prescription drugs", "health care services", "therapeutic class" and "rebates, fees, and any other remuneration" for purposes of reporting.

At this time, it is unclear whether the Departments will delay the Rx Reporting that is due December 27, 2021, but it is likely that the Departments will make their decision based on comments received from stakeholders in response to the RFI.

COBRA Subsidy Guidance Update

Background

On March 11, 2021, President Biden signed the *American Rescue Plan Act* (ARP) into law, which provided for a temporary 100% COBRA premium subsidy (Subsidy) and related tax credit. The Subsidy applies to qualified beneficiaries whose qualifying event was a reduction in hours or an involuntary termination of employment and who are still in their maximum COBRA period. Individuals are generally not eligible for the Subsidy if they are eligible for other group health plan coverage or Medicare. The statute refers to these individuals as "assistance eligible individuals" (AEIs). The Subsidy applies to both federal COBRA and state continuation coverage.

Following the passage of the ARP, the DOL issued FAQs (on April 7, 2021) and the IRS issued Notice 2021-32 (on May 18, 2021), which provide guidance on the Subsidy. Some of the key items included in the guidance include:

- *Required Notices*: Plan administrators and insurer are required to notify AEIs about the Subsidy – by

May 31, 2021 for AEIs with a qualifying event before April 1, 2021, and within the normal COBRA election notice timeframe for AEIs with a qualifying event on or after April 1, 2021. They must also notify AEIs about the Subsidy ending 15-45 days before the Subsidy ends. The DOL also provided model notices.

- *Qualifying Events for the Subsidy*: Under the ARP, an individual must experience a COBRA qualifying event based on either a reduction in hours or an involuntary termination of employment in order to qualify for the Subsidy. The Notice provides detailed Q&As outlining the circumstances in which a termination of employment is voluntary vs. involuntary and when an employee experiences a reduction in hours.
- *Claiming the Tax Credit*: A multiemployer plan (for multiemployer plans), employer (for insured and self-insured plans subject to federal COBRA), or insurer (for insured plans subject to state continuation coverage) (the "Premium Payee") is eligible for a tax credit for the premiums not paid by an AEI. The Premium Payee typically claims the tax credit on a Form 941. In anticipation of receiving the tax credit, a Premium Payee may also request an advance of the tax credit on a Form 7200. The Notice provides detailed instructions for claiming the tax credit. The IRS also recently released a revised Form 941 and revised instructions to Form 941 to provide additional guidance to Premium Payees claiming the tax credit.
- *Employee Attestation and Self-Certification*: Employers and insurers need to determine whether certain employees are eligible for the Subsidy. In order to assist with the determination, the Notice provides that employers can require individuals to self-certify or attest to their qualifying event and whether they are eligible for other health coverage that would result in the individual's loss of Subsidy eligibility. If an employer relies on an individual's attestation, it must keep a record of the attestation to substantiate eligibility for the tax credit.
- *Interaction with Outbreak Period Extensions*: The Notice confirms that the outbreak period extensions do not apply to either the required notices or elections under the ARP. However, the extensions do apply to retroactive periods of COBRA continuation coverage. Notably, under the Notice, an employer can require an individual to either elect or decline retroactive COBRA coverage when electing the Subsidy. An individual that declines retroactive COBRA will lose the right to elect the retroactive coverage in the future.

Dependent Care FSA Guidance Update

Background

On May 10, 2021, the IRS released Notice 2021-26 (Notice), which clarifies the tax treatment of dependent care reimbursements provided in connection with the new temporary carryover and extended grace period under the *Consolidated Appropriations Act, 2021* (CAA) and Notice 2021-15 and the interaction with the new temporary increased dependent care FSA exclusion under the *American Rescue Plan Act* (ARP). The key updates provided in Notice 2021-26 for calendar year plans include:

- *For 2020 plan year contributions that are received as reimbursements in 2021 due to a carryover or extended grace period* – If the amounts would have been excluded from income if they were received in 2020 (i.e., the reimbursements plus the reimbursements received in 2020 did not exceed $5,000), they will remain excludable in 2021.
- *For 2021 plan year contributions that are received as reimbursements in 2022 due to a carryover or extended grace period* – If the amounts would have been excluded from income if they were received in 2021 (i.e., the reimbursements plus the reimbursements received in 2021 did not exceed $10,500), they will remain excludable in 2022.

This is illustrated by the following example in the Notice:

An employee is covered by a calendar year cafeteria plan that offers a dependent care FSA. The employee elects no dependent care FSA for the 2019 plan year. The employee elects to contribute $5,000 to the dependent care FSA for the 2020 plan year, but incurs no dependent care expenses during the plan year. The employer adopts a carryover of unused dependent care amounts to the 2021 plan year. The employee elects to contribute $10,500 to the dependent care FSA for the 2021 plan year. The employee incurs $15,500 in dependent care expenses in 2021 and is reimbursed $15,500 by the dependent care FSA. The $15,500 is excluded from the employee's gross income and wages because $10,500 is excluded as 2021 benefits and the remaining $5,000 is attributable to a carryover.

The Notice also contains examples for how these rules work for non-calendar year dependent care FSA plans.

Final 2022 Notice of Benefit and Payment Parameters

On May 5, 2021, the Centers for Medicare and Medicaid Services (CMS) published the 2022 Notice of Benefit and Payment Parameters Final Rule (NBPP Final Rule).[13] This annual rulemaking by CMS addresses several *Patient Protection and Affordable Care Act* (ACA) provisions, including: Exchanges; risk adjustment; medical loss ratio; annual maximum out-of-pocket limit; and special enrollment periods. This summary discusses the NBPP Final Rule changes with regard to essential health benefits requirements, special enrollment periods, the premium adjustment percentage, the maximum annual limitations on cost-sharing, and the required contribution percentage.

Essential Health Benefits

The NBPP Final Rule did not alter essential health benefit coverage requirements. States remain authorized to annually select an essential health benefit benchmark plan in compliance with federal requirements. If altering essential health benefits, states should notify CMS in advance. CMS confirmed it will not take enforcement action for plan year 2021 against states that fail to provide an annual report regarding state-imposed benefit mandates that exceed the federal requirements. For plan year 2022, the annual report is due July 1, 2022 and CMS has indicated willingness to issue technical guidance to assist with compliance.

Special Enrollment Periods

The NBPP Final Rule provides for a special enrollment period (SEP) in the individual market when an individual or their dependent is enrolled in *Consolidated Omnibus Budget and Reconciliation Act of 1985* (COBRA) continuation coverage (including state COBRA), and the employer or government entirely ceases its contributions or subsidies to COBRA. The continuation coverage encompasses the subsidies ending September 30, 2021 under the *American Rescue Plan* (ARP) and, therefore, this SEP for the individual market will be available when the ARP subsidies expire. CMS did not finalize rules concerning a special enrollment period if an employer or the government reduces, but does not entirely cease, its COBRA contributions or subsidies.

Premium Adjustment Percentage

The premium adjustment percentage, fixed annually by the Secretary of Health and Human Services, measures premium growth and is utilized to set the maximum annual cost-sharing limit, employer mandate penalty amounts, and the contribution percentage for exemption eligibility. Significantly, the NBPP Final Rule did not finalize the proposed rule's premium adjustment percentage formula and instead adopted the 2015-2019 formula, which will result in lower out-of-pocket costs for consumers. The 2022 plan year premium adjustment percentage is approximately 1.376, which is only a 1.6 percentage increase from the 2021 plan year.

Maximum Annual Limitation on Cost-Sharing

For the 2022 plan year, the maximum out-of-pocket limitation on cost-sharing for group health plans is $8,700 for self-only coverage and $17,400 for coverage other than self-only. While the limitation has increased, the rate is less than the proposed rule's projections due to the Biden Administration's altered methodology (adoption of the premium adjustment percentage formula used 2015-2019). Beginning in plan year 2023, CMS plans to publish the new maximum annual limit on cost-sharing and other ACA indexed amounts in annual guidance issued in January of the year before the year to which the amounts relate, unless the methodology is altered. This should be helpful for plans to have information sooner than waiting for the annual Payment Notice rulemaking to be finalized.

ACA Section 1557 Nondiscrimination

The Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued a Notification of Interpretation and Enforcement on Section 1557 of the *Patient Protection and Affordable Care Act* (ACA).[14] The Notice provides that, beginning as of May 10, 2021, OCR will interpret and enforce Section 1557 and the prohibition on discrimination based on sex to include: 1) discrimination based on sexual orientation; and 2) discrimination based on gender identity.

Background

Section 1557 of the ACA prohibits discrimination based on race, color, national origin, sex, age, or disability in covered

[13] 85 Fed. Reg. 24140 (May 5, 2021).
[14] 86 Fed. Reg. 27984 (May 10, 2021).

health programs or activities, and the implementing regulation issued by OCR applies to entities that receive federal financial assistance from HHS. Section 1557 incorporates the Title IX of the Education Amendments of 1972's (Title IX) prohibition on sex discrimination.

Nondiscrimination Based on Sexual Orientation and Gender Identity

OCR issued the Notice to clarify that it will interpret and enforce ACA Section 1557's prohibition on discrimination on the basis of sex to include discrimination based on sexual orientation and discrimination based on gender identity. This interpretation stems from the Supreme Court's decision in *Bostock v. Clayton County, GA*,[15] where the Supreme Court ruled that Title VII's prohibition on employment discrimination based on sex encompasses discrimination based on sexual orientation and gender identity. In the Notice, OCR notes that since *Bostock*, two federal circuit courts have concluded that the plain language of Title IX's prohibition on sex discrimination must be read similarly. In addition, on March 26, 2021, the Civil Rights Division of the U.S. Department of Justice issued a memorandum to Federal Agency Civil Rights Directors and General Counsel concluding that the Supreme Court's reasoning in *Bostock* applies to Title IX. OCR notes that this interpretation will guide it "in processing complaints and conducting investigations, but does not itself determine the outcome in any particular case or set of facts."

OCR also noted it will comply with the *Religious Freedom Restoration Act* and all other legal requirements when enforcing Section 1557, and will comply with any applicable court orders involving the Section 1557 regulations.

[15] 140 S. Ct. 1731 (2020).

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