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INSIGHT

Legislative Update

IN THIS ISSUE

Build Back Better Act

At the top of Congress's 2022 agenda is tying up loose ends from 2021, including passing:

- Some or all of President Biden's social spending package, the *Build Back Better Act*; and
- A 2022 federal budget before previous stop-gap funding expires on February 18, 2022.

While early versions of the *Build Back Better Act* contained several provisions related to retirement, most of those provisions were removed during various revisions throughout the fall. It is also still uncertain which health care and prescription drug pricing provisions remain under consideration.

The fate of the *Build Back Better Act* was cast into doubt in December 2021 when Senator Joe Manchin (D-WV) withdrew from negotiations on the bill. On January 4, 2022, Sen. Manchin indicated that he was indeed done with negotiations on the *Build Back Better Act*, but could possibly work with Democrats on some climate change provisions.

Shortly after Sen. Manchin's pronouncement, Senate Majority Leader Chuck Schumer (D-NY) announced that his priority for his chamber in January was voting rights, followed by climate change and lowering health care and prescription drug costs. Voting rights and the federal budget will likely occupy Congress through mid-February, so it is unlikely there will be meaningful retirement plan changes in the near future.

Infrastructure Investment and Jobs Act

The *Infrastructure Investment and Jobs Act* (IIJA) was signed into law by President Biden on November 15, 2021. Although largely relating to infrastructure, the bill made two changes that may affect qualified retirement plans; however, only the first change impacts governmental plans:

- Expanded and streamlined the automatic 60-day extension of numerous pension-related IRS deadlines for "federally declared disasters."
- Extended interest rate smoothing provisions affecting minimum funding requirements for the majority of non-governmental defined benefit plans. These provisions originated from the *Moving Ahead for Progress in the 21st Century Act* (MAP-21), and have been extended and enhanced several times, including in the recent *American Rescue Plan Act of 2021* (ARPA).

IRS Makes Changes to Correction Program

On July 16, 2021, the Internal Revenue Service (IRS) released Revenue Procedure 2021-30 (Rev. Proc. 2021-30)[1], which included new procedures for the Employee Plans Compliance Resolution System (EPCRS). EPCRS gives plan sponsors a way to correct certain types of errors that may result in loss of tax-qualification if left unresolved. Important changes to EPCRS made by Rev. Proc. 2021-30 include:

- Elimination of anonymous submissions under the Voluntary Correction Program (VCP) and institution of anonymous pre-submission conferences;
- Changes to rules for recovering plan overpayments; and
- Expansion of the Self Correction Program (SCP).

Elimination of the Anonymous VCP

Under Rev. Proc. 2021-30, anonymous VCP submissions were eliminated effective January 1, 2022. Previously, plan sponsors relied on anonymous VCP submissions to address and resolve complex or thorny issues with the IRS. This process provided an avenue for governmental plans to seek resolution without being tied into an undesirable or expensive IRS-required correction, particularly as they often lack a source of funds for unexpected correction costs. If an issue was unable to be resolved through an anonymous VCP, a plan sponsor could withdraw the application and remain anonymous.

The anonymous application process has been replaced with an anonymous VCP pre-submission conference. As of January 1, 2022, plan sponsors can request a VCP pre-submission conference *prior* to submitting a VCP application for errors for which:

- A compliance statement may be issued under EPCRS by the IRS;
- The correction method is not described as a safe harbor correction method in Appendix A or B to Revenue Procedure 2021-30; and
- The plan sponsor intends to submit a VCP application.

In preparation for the conference, plan sponsors will submit a description of the failure, relevant facts and plan provisions, and proposed corrections. Notably, the submission, conference, and IRS opinions are not binding on the IRS. Other key differences from the prior process include:

- The granting of a pre-submission conference is subject to IRS discretion; and
- Pre-submission conferences are not subject to a fee, whether or not the plan sponsor decides to file a VCP after the conference. (Previously, the IRS retained an anonymous VCP filing fee even if the plan sponsor withdrew the application.)

Given the complexity of some of their corrections, a number of governmental plans have chosen the anonymous filing approach in the past. This change to EPCRS could be significant in determining how to approach corrections of operational and document "failures" in the future.

Changes to Overpayment Recoupment

The IRS also updated its rules for overpayment recovery under Rev. Proc. 2021-30. Previously, plans were generally required to recoup all overpayments from both members and beneficiaries, or otherwise make the plan whole (e.g., the plan sponsor would have to contribute the difference to the plan, plus earnings).

Under Rev. Proc. 2021-30, plan sponsors will be allowed to utilize the following new rules:

- *Higher de minimis overpayment/excess amount limit*: The amount considered a de minimis overpayment not requiring repayment or notice that the overpayment is not eligible for rollover is increased from $100 to $250. In the same vein, an excess amount not exceeding $250 (also up from $100) need not be distributed or forfeited, although a member must still be notified that an excess amount exceeding a statutory limit is not rollover-eligible.
- *Plan amendments, installment payments, and adjustments to future contributions*: Both defined benefit and defined contribution plans may now

[1] https://www.irs.gov/pub/irs-drop/rp-21-30.pdf

accept overpayments from members and beneficiaries via lump sum or installment repayment, or through an adjustment to future payments. Sponsors can also correct overpayments by amending their plan to reflect operations that led to the overpayment.

- *Funding Exceptions*: Two additional methods of relief were included in the Revenue Procedure, the "Funding Exception Correction Method" and the "Contribution Credit Correction Method." However, relief under both of these methods is based, at least in part, on the plan's minimum funding requirements. Since these funding requirements do not apply to governmental plans, it is not yet clear the extent to which such relief is available to these plans.

Expansion of the Self-Correction Program

Rev. Proc. 2021-30 also expanded the availability of self-correction, effective as of July 16, 2021. The correction period for significant operational and plan document failures under the Self-Correction Program (SCP) is extended from two years to three years. This allows plan sponsors and providers extra time to identify and self-correct significant errors, hopefully lessening the need for the more expensive VCP process and lowering the risk for disqualification of the plan.

This expansion also increases the availability of retroactive plan amendments to correct operational failures. Plan sponsors may now use a retroactive plan amendment to self-correct an operational failure that increases a benefit, right, or feature even if that increase does not apply to all eligible members.

IRS Issues Guidance on Reemploying Retirees and In-Service Distributions

On October 22, 2021, with the goal of alleviating pressure on a tight labor market due to the pandemic, the IRS released guidance in the form of Frequently Asked Questions (FAQs) regarding the rehire and retention of employees after retirement age. [2]

While the first FAQ includes the example of a rehire necessitated by the COVID-19 pandemic, the principles apply more broadly. Consistent with the limited guidance previously available, the FAQ provides that the rehire of a member who had a "bona fide retirement" (based on the facts and circumstances or under plan terms), where there was no prearrangement for the member to return to service, will not cause the prior retirement to lose its bona fide status. Therefore, payment of the member's benefit prior to rehire would not be an impermissible in-service distribution and the member may continue to receive retirement benefits after rehire (subject to plan terms limiting such payment (e.g., suspension of benefit provisions)).

The second FAQ confirms that, if the plan terms allow it, employees can receive in-service benefit distributions after attainment of age 59 ½ or the plan's normal retirement age, consistent with the Internal Revenue Code (Code) and Treasury Regulations. If the member receives a distribution prior to age 59 ½ (i.e., if the plan has a lower normal retirement age), the distribution may be subject to the 10% additional tax under Code section 72(t).

Although the FAQs are not official "guidance", the IRS has stated that reasonable reliance in good faith on an FAQ will give rise to a "reasonable cause" defense against penalties in the event the FAQ turns out to be incorrectly applied to the taxpayer's facts and circumstances.[3]

New Guidance on Coverage of Over-the-Counter COVID-19 Tests

In early December, President Biden announced new actions to combat COVID-19, including a commitment to expand access to free at-home COVID-19 tests. In announcing his plan, the President directed the Departments of Labor, Health and Human Services, and the Treasury (the Departments) to issue guidance clarifying that individuals who purchase over-the-counter (OTC) COVID-19 diagnostic tests during the public health emergency will be able to seek reimbursement from their group health plan or health insurance issuer.

[2] https://www.irs.gov/newsroom/coronavirus-related-relief-for-retirement-plans-and-iras-questions-and-answers#rehires

[3] https://www.irs.gov/newsroom/irs-updates-process-for-frequently-asked-questions-on-new-tax-legislation-and-addresses-reliance-concerns

On January 10, 2022, the Departments released a set of Frequently Asked Questions (FAQs) in response to the President's directive. The FAQs also address questions regarding coverage of colorectal screenings and contraceptive services as preventive services.

Under the President's directive and the FAQs, plans and issuers must cover OTC COVID-19 tests without imposing any cost-sharing requirements, prior authorization, or other medical management requirements. This builds on the requirement under the *Families First Coronavirus Response Act* (FFCRA), as amended by the *Coronavirus Aid, Relief, and Economic Security* (CARES) *Act* that group health plans and health insurance issuers cover in vitro diagnostic COVID-19 tests without cost-sharing if they meet certain criteria, such as FDA approval or emergency use authorization.

OTC COVID-19 Test Coverage Requirements

Plans and issuers must cover, without cost-sharing, OTC COVID-19 tests that meet the statutory criteria under the FFCRA and CARES Act, including tests obtained without an order or individualized clinical assessment by a health care provider. This expands prior guidance that limited coverage of at-home COVID-19 tests to situations in which the test was ordered by a provider. Plans and issuers are not required to reimburse sellers of OTC COVID-19 tests directly (direct coverage) and may instead require that a covered individual submit a claim for reimbursement. However, plans and issuers are strongly encouraged to provide direct coverage for OTC COVID-19 tests so that covered individuals are not required to pay upfront for such tests.

Cost and Quantity Limits

Plans and issuers cannot limit coverage of OTC COVID-19 tests to only those that are provided through preferred pharmacies or other retailers. However, if plans and issuers arrange for direct coverage of OTC COVID-19 tests through both their pharmacy network and a direct-to-consumer shipping program, they can limit OTC COVID-19 tests from non-preferred pharmacies or other retailers to no less than the actual price or $12 per test.

Plans and issuers must take reasonable steps to ensure that enrollees have adequate access to OTC COVID-19 tests by making sure that tests are available through a sufficient number of in-person and online retail locations. Additionally, the direct-to-consumer shipping program may be provided through one or more in-network provider(s) or another entity designated by the plan or issuer.

Plans and issuers can also limit the number of OTC COVID-19 tests provided pursuant to the FAQs if they cover at least 8 tests per 30-day period (or calendar month) for each covered individual. The options to create a point of sale coverage network (and limit tests purchased outside of the network to a maximum of $12) and to limit the number of covered tests each month only apply with respect to OTC COVID-19 tests that are administered without a provider's involvement or prescription. When a provider is involved, plans and issuers must continue to provide coverage for COVID-19 tests in accordance with prior guidance.

The Prevention of Fraud and Abuse

Plans and issuers may take reasonable steps to prevent, detect, and address fraud and abuse. For example, plans and issuers could require an attestation that the test was purchased for the covered individual's own use. Plans and issuers may also require reasonable documentation of proof of purchase with a claim for reimbursement of the cost of the OTC COVID-19 test.

Effective Date

Plans and issuers must provide coverage in accordance with the FAQs for OTC COVID-19 tests purchased on or after January 15, 2022 and during the public health emergency.

Prescription Drug and Health Care Spending Transparency Interim Final Regulations

Enacted on December 27, 2020, Section 204 of the *Consolidated Appropriations Act of 2021*, amended the Internal Revenue Code, the *Employee Retirement Income Security Act of 1974*, and the *Public Health Service Act* to add provisions requiring transparency regarding health coverage and costs. This provision requires group health plans and issuers to report information about pharmacy benefits and drug costs annually to the Departments of Labor, Health and Human Services, and the Treasury (the Departments).

On November 23, 2021, the Departments published Interim Final Regulations (IFR), "Prescription Drug and Health Care Spending," outlining requirements for the reporting. Comments were due by January 24, 2022. The new requirements apply to group health plans, including grandfathered plans, non-Federal governmental plans, church plans, federal employee health benefit plans (FEHB plans), individual health insurance coverage, and student health insurance. Excepted benefits are exempt from these requirements.

Plans and issuers are required to submit the reports based on "reference year," which means the calendar year immediately preceding the calendar year in which the reports are due. The Departments noted that they will not initiate enforcement against a plan or issuer if the December 27, 2021 and June 1, 2022 reports are submitted by December 27, 2022. Thereafter, plans and issuers must annually submit the reports by June 1st.

The information to be submitted includes:

- Total annual spending on health care services, broken down by types of cost including: (i) hospital costs; (ii) health care provider and clinical service costs, for primary care and specialty care separately; (iii) costs for prescription drugs; and (iv) other medical costs, including wellness services.
- Average monthly premiums paid by employers on behalf of participants, beneficiaries, and enrollees, as well as the average monthly premium paid by participants, beneficiaries and enrollees, as applicable.
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage and the total number of paid claims for each drug.
- The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending per drug reporting of the total cost sharing paid by participants, beneficiaries, and enrollees.
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is subject of the report and for each such drug, the change in amounts expended by the plan or coverage in each such plan year.
- Information about prescription drug rebates, fees, and any other remuneration.

Each report that is submitted must include identifying information at the plan or coverage level. In addition, plans and issuers should ensure that the information that is reported includes: (i) the beginning and end dates of the plan year that ended on or before the last day of the reference year; (ii) number of participants on the last day of the reporting year; and (iii) each state in which the plan or coverage is offered. This information is the only information that must be reported at the plan-level. All of the other information should be reported on an aggregate basis by State and market segment.

If a Pharmacy Benefit Manager (PBM) or Third-Party Administrator (TPA) submits data on behalf of more than one group health plan in a State, the IFR provides that information from all the group health plans should be aggregated by State and market segment. Self-funded group health plan information must be reported based on the State where the plan sponsor has its principal place of business, with certain exceptions, and fully-insured policies should be reported based on the State where the policy was issued. The aggregate reports for each State should be broken out by the following market segments: (i) individual market (excluding the student market); (ii) fully-insured small group market; (iii) fully-insured large group market (excluding the FEHB plans); (iv) small employer self-funded plans; (v) large employer self-funded plans; and (vi) the FEHB line of business.

Special rules apply if there are multiple reporting entities for one or more plans or issuers in a State and market segment. In this case, the data submitted by each reporting entity may not be aggregated at a less granular level than the aggregation level used by the reporting entity that submits the data on total annual spending on health care services.

Plans may satisfy the reporting requirements by contracting with third parties to submit such information on their behalf. If a plan sponsor enters into a written agreement with a fully-insured plan to submit the report on its behalf, the IFR provides that the issuer – and not the plan – is liable for any reporting failures. However, self-funded plan sponsors remain liable for the reporting (even if the plan sponsor enters into a written agreement for a third party (such as a PBM or TPA) to submit the report on their behalf .

Within 18 months of first receiving this information and on a biannual basis thereafter, the Departments will publish on its website a report on prescription drug reimbursements for plans and coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increase or decreases under such plans or coverage.

IRS Proposes ACA Reporting Relief and Deadline Extensions

On November 22, 2021, the IRS issued proposed regulations that provide an automatic 30-day deadline extension and reporting relief for Forms 1095-B and 1095-C. Under the statutory language of the Affordable Care Act (ACA), these forms (which provide information about the offers of and enrollment in health coverage during the prior year) are due to individuals by January 31, 2022. Due to the significant challenges caused by these reporting requirements, the IRS has annually issued temporary notices extending the deadline for furnishing these forms, as well as provided good faith relief from reporting penalties.

The proposed regulations make the extension permanent, but no longer provide the good faith relief. The proposed regulations apply for calendar years beginning after December 31, 2021, although taxpayers may rely on them for calendar years beginning after December 31, 2020.

The substantive changes under the proposed regulations include:

- *Automatic 30-day Extension for Furnishing Form 1095-B or 1095-C:* An automatic 30-day extension for furnishing the Forms 1095-B or 1095-C to individuals. If the extended deadline falls on a weekend day or legal holiday, the forms are due on the next business day. The deadline to file the forms with the IRS is not extended, but reporting entities can request a 30-day extension.
- *Alternative Method of Furnishing Forms 1095-B or 1095-C to Individuals:* Reporting entities are not required to furnish Forms 1095-B or 1095-C to individuals, as long as the employer or reporting entity posts a "clear and conspicuous notice" on the entity's website stating that responsible individuals may receive a copy of their statement upon request. This notice must include an email address, a physical address to which a request for a statement may be sent, and a telephone number where individuals can contact the reporting entity with questions. The entity must retain the notice on its website until October 15th of the year following the calendar year to which the form relates. However, this relief does not apply with respect to furnishing Form 1095-C to full-time employees.
- *End of Transitional Good Faith Relief:* The good faith relief is no longer available for reporting year 2021 (the forms due in 2022) and subsequent years.

About GRS

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