LEGISLATIVE AND REGULATORY DEVELOPMENTS IN 2021 OF INTEREST TO CHURCH-SPONSORED EMPLOYEE BENEFIT PLANS AND PROGRAMS

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I. LEGISLATION AND LEGISLATIVE INITIATIVES

A. Consolidated Appropriations Act, 2021

President Trump signed the Consolidated Appropriations Act, 2021 into law on December 27, 2020 (the "CAA").[1] The CAA includes several provisions impacting employee benefit plans, including the following:

- Restrictions on surprise medical billing.
- Transparency requirements for group health plans.
- Mental health parity nonquantitative treatment limitation documentation and comparative analysis requirements.
- Temporary flexible spending account ("FSA") flexibility.
- Mandatary prescription drug reporting requirements.

Additional guidance has been issued on many of these provisions. See Section III below for a description of each of these CAA provisions and the additional guidance issued with respect to them.

B. American Rescue Plan Act of 2021

On March 11, 2021, President Biden signed into law the COVID-19 relief legislation known as the American Rescue Plan Act of 2021 ("ARPA").[2] Among many other provisions, the ARPA contains a temporary COVID-19 subsidy for continuation coverage premiums under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") or state laws that are similar to COBRA, along with a temporary increase of the limit on the amount that can be excluded from income through a dependent care FSA. These provisions are discussed in more detail in Section IV below, along with the implementing guidance that has been issued.

C. Infrastructure Investment and Jobs Act

On November 15, 2021, President Biden signed into law the Infrastructure Investment and Jobs Act ("IIJA").[3] The IIJA mainly includes provisions relating to infrastructure but also includes a few provisions impacting employee benefit plans, including the following:

- Automatic Deadline Extensions for Disasters: The IIJA provides for an automatic extension of 60-days for specified Internal Revenue Service ("IRS") filing deadlines resulting from certain federally-declared disasters. As a result, taxpayers will no longer be required to wait for the IRS to grant certain deadline

[1] Public Law No. 116-260.

[2] Public Law No. 117-2.

[3] Public Law No. 117-58.

extensions. The automatic extension applies to the deadlines for individual tax filings, qualified retirement plan contributions, excess IRA contribution distributions, recharacterizing IRA contributions, and completing 60-day rollovers.

- Federally Declared Disasters: The IIJA also amends the definition of "federally declared disaster" to include a "significant fire" as one of the disasters for which the IRS can extend tax filing deadlines on a discretionary basis.

- Delay of Final Regulations on Prescription Drug Rebates under Medicare Part D: The final rules, which were issued toward the end of the Trump administration, would eliminate safe harbor protection under the anti-kickback statute for rebates on prescription drugs paid by pharmaceutical companies to pharmacy benefit managers ("PBMs") and Medicare Part D plans. The final rules also add safe harbors for point-of-sale discounts on prescription drugs and fixed-fee service arrangements between drug manufacturers and PBMs. The IIJA delays the effective date of these regulations until January 1, 2026.[4]

The IIJA also provides for the early termination of the employee retention credit as of September 30, 2021, subject to a limited exception.[5]

D. Church Alliance Legislative Initiatives

1. Commodity Pool Operator Fix

The Dodd-Frank Act amended the Commodity Exchange Act's definition of "commodity pool operator" ("CPO"), expanding the universe of entities that must register as such. Under the applicable regulations, church plans are generally excluded from the "pool" definition in 17 CFR §4.10(d)(1). However, there is some concern that if an entity (e.g., a church benefits board), commingles plan assets with non-plan assets for investment purposes, then it could qualify as a "pool" if it trades in qualifying commodity interests and, therefore, would be required to register as a commodity pool operator. Trading in qualifying commodity interests includes investing or retaining investment managers that invest in such interests.

The Church Alliance continues to work on the CPO clarification issue, though advancement continues to face headwinds as Congress has been working through health and economic legislation. With a new Congress, the focus has been on reintroduction in the House and Senate. Senator Amy Klobuchar (D-MN) has indicated that she would like to continue to lead the legislation; in addition, the Church Alliance has been in touch with a Senate Republican office potentially interested in taking over the role of lead Republican sponsor following the loss of Senator David Perdue (R-GA), the previous Senate Republican champion.

[4] The Build Back Better Act, which is further discussed in Section I.E.3 below, would repeal these regulations, if enacted.

[5] Prior to the enactment of the IIJA, the employee retention credit had been extended to include wages paid through December 31, 2021, by the CAA and the ARPA. See Section V.E below for additional information.

The Church Alliance continues to work with the Senate and House Agriculture Committee staffs to identify opportunities to advance the CPO fix, either as part of a moving vehicle, though acknowledging one may not be available in the near term, or as stand-alone legislation.

E. Proposed Legislation

1. Securing a Strong Retirement Act of 2021

On May 4, 2021, Ways and Means Committee Chairman Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) introduced the Securing a Strong Retirement Act of 2021 (H.R. 2954) in the U.S. House of Representatives. This bill is commonly referred to as "SECURE 2.0" because it follows the Setting Every Community Up for Retirement Enhancement Act of 2019 (the "SECURE Act") and provides additional changes to retirement plan rules intended to help Americans save for retirement. If passed, SECURE 2.0 includes provisions that would:

- Expand automatic enrollment in retirement plans.
- Modify the start-up credit for small employers.
- Expand 403(b) plan investments to include collective investment trusts (also known as 81-100 group trusts).
- Increase the required beginning date under the required minimum distribution ("RMD") rules to age 75.
- Reduce the RMD excise tax.
- Remove RMD barriers for life annuities.
- Create an RMD exemption for balances under $100,000.
- Index the IRA catch-up contribution limit.
- Increase the limit on age 60 catch-up contributions for individuals age 62 to 64 in 401(k) plans to the lesser of $10,000 or the participant's compensation reduced by any other elective deferrals for the year.
- Permit matching contributions based on qualified student loan payments if certain requirements are satisfied.
- Simplify and increase the Saver's Credit.
- Create a start-up credit for small employers participating in multiple employer plans ("MEPs").
- Permit small, immediate financial incentives for plan contributions.

- Create a safe harbor for correcting certain elective deferral failures.
- Reduce the period of service requirement for long-term, part-time employees from three years to two.
- Liberalize qualified longevity annuity contract rules.
- Revise the rules applicable to recovering retirement plan overpayments.
- Revise the rules applicable to performance benchmarks for asset allocation funds.
- Require certain government agencies to study the reporting and disclosure requirements on plan sponsors and submit a report to Congress.
- Eliminate unnecessary plan requirements related to unenrolled participants.
- Create a retirement savings "lost and found" registry.

The SECURE Act included a provision permitting unrelated employers to participate in a multiple employer defined contribution plan that is treated as a single employer plan, provided a "pooled plan provider" is utilized to administer the plan. These plans are referred to as "pooled employer plans." SECURE 2.0 would expand this provision to permit 403(b) pooled employer plans but includes a carve out to exclude church 403(b) plans from this rule.

Finally, SECURE 2.0 includes provisions that would impact student loan payments. These provisions are similar to the provisions included in the Retirement Security and Savings Act and are further described in Section I.E.2 below.

2. Retirement Security and Savings Act

On May 20, 2021, Senators Rob Portman (R-OH) and Ben Cardin (D-MD) re-introduced the Retirement Security and Savings Act of 2021 (S. 1770) ("Cardin-Portman"), which is bipartisan legislation aimed at strengthening the retirement security of Americans.[6] Cardin-Portman includes many provisions that are like SECURE 2.0 along with some additional provisions that would:

- Allow mergers of 401(a) and 403(b) plans.
- Harmonize hardship rules for 401(k) and 403(b) plans.
- Add a new automatic enrollment safe harbor plan design.
- Expand rollovers for non-spouse beneficiaries.
- Permit certain types of contributions based on severance payments.

[6] The Church Alliance sent Senators Portman and Cardin a "thank you" letter for re-introducing the Cardin-Portman.

Both SECURE 2.0 and Cardin-Portman include provisions relating to student loans. These provisions would permit employers to make matching contributions under 401(k) and 403(b) plans based on student loan payments, and the payments would not cause the plans to incur universal availability failure. These provisions would also require the matching rate for student loan payments to be the same as the matching rate for elective deferrals. In addition, matching contributions for student loan payments only would be available to employees otherwise eligible to receive regular matching contributions, and all employees who are eligible for the regular match must be eligible to receive a match on student loan payments.

3. Build Back Better Act

On November 19, 2021, the U.S. House of Representatives approved the Build Back Better Act (H.R. 5376) ("BBBA"), an approximately $1.75 trillion budget reconciliation bill that includes many key Democratic priorities. The bill includes several provisions impacting employee benefit plans, including the following provisions that would:

- Change the affordability threshold under the employer mandate provisions of the Affordable Care Act ("ACA") from 9.5% of household income to 8.5% of household income and remove the indexing of this number.

- Increase the subsidies for individuals who purchase health insurance through the ACA Marketplace.

- Through 2025, permit individuals with household incomes at or below 138% of the federal poverty level who live in states that have not expanded Medicaid to receive a Marketplace subsidy even if they were offered affordable, minimum value employer-sponsored health coverage.

- Authorize the Department of Labor ("DOL") to assess additional monetary penalties for enforcement of the mental health parity requirements.

The BBBA would also guarantee four weeks of paid family and medical leave during a 52-week period for all workers. The paid leave would be funded in one of three ways: (1) a new public program administered by the Department of Treasury; (2) existing "legacy" state leave programs; or (3) employer-sponsored paid leave programs. Federal grants would be provided to "legacy" states and employers providing paid leave programs that are at least as generous as the federal program.

The BBBA also includes the following retirement-related revenue raisers to help offset the cost of the bill:

- Effective for 2029, a cap of $10 million on IRA and defined contribution plan vested account balances.

- Effective for 2022, elimination of "backdoor" Roth contributions.[7]

- Effective for 2032, elimination of Roth conversions for high-income taxpayers.

- Creation of a six-year statute of limitations for certain IRS reporting and prohibited transactions.

- Effective for transactions after 2021, treatment of IRA owners and beneficiaries as disqualified persons under the prohibited transaction rules.

The bill has been sent to the Senate where it will in all likelihood undergo revisions.

4. Telehealth Expansion Act

During the year, bipartisan legislation known as the Telehealth Expansion Act was introduced in both the U.S. House of Representatives and the Senate.[8] The legislation would make permanent a provision included in the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") that permits high deductible health plans ("HDHPs") to provide pre-deductible coverage of telehealth services without jeopardizing a participant's ability to make health savings account ("HSA") contributions.

5. Retirement Savings Lost and Found Act

On May 20, 2021, Senators Elizabeth Warren (D-MA) and Steve Daines (R-MT) reintroduced bipartisan legislation to make it easier for former employees to claim their retirement benefits from plans maintained by former employers. The Retirement Savings Lost and Found Act of 2021 (H.R. 5832) ("RSLA") would create an Office of Retirement Savings Lost and Found at the Pension Benefit Guaranty Corporation ("PBGC") that would provide a searchable plan registry that individuals could use to find the retirement plans of their former employers and claim missing benefits. The registry would also include information about small account balances that were transferred to IRAs. Employers would be required to report information about small balance transfers to the IRS on existing forms. The RSLA would also increase the cash-out limit from $5,000 to $6,000 and require plans to transfer account balances of $1,000 or less after a period of time to the Office of Retirement Savings Lost and Found.

II. BIDEN ADMINISTRATION ACTIONS

When a new party takes control of the White House, it is customary to see several executive orders issued or other actions taken that reverse regulatory actions from the previous administration or provide additional time for review of such actions. Below is a brief description of some of the actions taken by the Biden administration that may impact employee benefit plans and church employers.

[7] Certain individuals cannot make a Roth IRA contribution due to the income limits. An individual can currently avoid the income limit by making a "backdoor" after-tax contribution to a traditional IRA and then converting the IRA to a Roth IRA.

[8] H.R. 5981; S. 1704.

A. Regulatory Freeze

On January 21, 2021, the Biden administration issued a memorandum[9] imposing a regulatory freeze pending review. The memorandum requests that executive departments and agencies:

- Refrain from proposing or issuing a rule until reviewed and approved by the administration, subject to exceptions for certain emergency situations and urgent circumstances.

- Withdraw rules that have been sent to the Office of Federal Register for review but have not yet been published.

- Consider postponing the effective date for 60 days of any rules that have been published in the Federal Register (or issued in another manner) but have not yet taken effect.

For rules that are described in the third bullet, the memorandum provides additional guidance on the steps agencies should take after postponing the effective for 60 days following a rule's publication in the Federal Register.

The regulatory freeze impacts the following benefits-related regulations:

- The DOL final prohibited transaction exemption published on December 18, 2020, that would have been used in connection with the final fiduciary regulations issued in 2020 that reinstated the five-part test for determining fiduciary status.[10] These regulations will go into effect but are subject to a temporary enforcement policy, which is further discussed in Section VI.B.3 below.

- The DOL final regulations published on January 7, 2021, on the standards for determining whether a worker is an employee or independent contractor under the Fair Labor Standards Act. These rules were withdrawn.

- The Treasury Department and IRS final regulations on the application of the employer mandate to individual coverage health reimbursement arrangements (which had not yet been published). These rules were withdrawn.

- The proposed rules of the Equal Employment Opportunity Commission ("EEOC") on wellness program incentives (which had not yet been published). These rules were withdrawn.

[9] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/regulatory-freeze-pending-review/.

[10] 85 Fed. Reg. 82,798.

B. Executive Orders

President Biden issued several executive orders shortly after entering office that impact employee benefit plans and the COVID-19 pandemic, including executive orders that:

- Announce the administration's policy to prevent and combat discrimination based on gender identity or sexual orientation and require each agency to consider revising, suspending, or rescinding any agency actions that are inconsistent with this policy or promulgating new actions as necessary to fully implement this policy.[11]

- Require COVID-19 vaccines for federal employers and employees of contractors that do business with the federal government and ensuring COVID-19 safety protocols are in place for federal employees.[12]

On July 9, 2021, President Biden issued an Executive Order[13] on promoting competition in health care and other areas. The executive order affirms the administration's policy to increase competition in health care by enforcing antitrust laws, directs various actions aimed at combating the excessive cost of prescription drugs,[14] directs the Department of Health and Human Services ("HHS") to support existing price transparency initiatives for hospitals and other providers, directs HHS to implement standardized plan options in the ACA marketplaces so individuals can better compare plan options, and directs HHS to publish a proposed rule allowing over-the-counter hearing aids to promote more widely-available and lower cost hearing aids.

C. COVID-19 Action Plan

The Biden administration announced a strategy to combat COVID-19.[15] The strategy includes vaccine mandates that would impact large employers with 100 or more employees and health care facilities that receive Medicare or Medicaid reimbursement.

On November 4, 2021, the Occupational Safety and Health Administration issued an Emergency Temporary Standard ("ETS") implementing the strategy for employers with 100 or

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[11] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-combating-discrimination-on-basis-of-gender-identity-or-sexual-orientation/.

[12] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-requiring-coronavirus-disease-2019-vaccination-for-federal-employees/ and https://www.whitehouse.gov/briefing-room/presidential-actions/2021/09/09/executive-order-on-ensuring-adequate-covid-safety-protocols-for-federal-contractors/.

[13] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/07/09/executive-order-on-promoting-competition-in-the-american-economy/.

[14] On September 9, 2021, HHS issued a report in response to the Executive Order describing a comprehensive plan for addressing high drug prices. *See* https://aspe.hhs.gov/sites/default/files/2021-09/Competition%20EO%2045-Day%20Drug%20Pricing%20Report%209-8-2021.pdf.

[15] *See* https://www.whitehouse.gov/covidplan/.

more employees. Under the ETS, large employers[16] must require all employees[17] either to be fully vaccinated for COVID-19 or to produce a negative COVID test on a weekly basis and wear a face covering at work (subject to certain exceptions). In addition, the ETS also requires large employers to provide paid time off to employees so they can get vaccinated and recover from any side effects of the vaccine. The ETS also provides guidance on acceptable forms of proof of vaccination status, how to comply with the testing requirements for unvaccinated employees, certain exceptions that apply to the vaccination requirement, how to handle positive COVID-19 tests, and reporting requirements for COVID-19-related fatalities.

Subject to the outcome of the litigation discussed below, employers are required to comply with the guidance by December 5, 2021, except for the weekly testing requirements. The weekly testing requirements become effective January 4, 2022. The penalties for noncompliance are the same as those that apply to other violations of Section 17 of OSHA, which can be as high as $13,653 per violation and up to $136,532 per willful violation.

On November 5, 2021, the Centers for Medicare and Medicaid released an interim final rule requiring most health care employers that receive Medicare or Medicaid reimbursement to ensure their staff is fully vaccinated. Subject to the outcome of the litigation described below, the rule requires the vaccination requirements to be fulfilled in two phases. For phase 1, all staff must receive the first dose of a series or a single dose COVID-19 vaccine by December 5, 2021. For phase 2, all staff must complete the vaccine series by January 4, 2021. The rules also provide guidance on certain exemptions that apply and the documentation requirements for showing proof of vaccination.

Litigation has been filed to enjoin both rules. The Fifth Circuit Court of Appeals recently suspended the rules requiring large employers to require employees to be vaccinated or produce a weekly negative COVID-19 test.[18] On November 16, 2021, the U.S. Judicial Panel on Multidistrict Litigation decided that the Sixth Circuit will hear consolidated challenges to the large employer rules. Additional litigation is expected in the future.

D. Other Priorities

Although action has not yet been taken, President Biden has also vowed to restore the ACA contraceptive mandate that was in place prior to the U.S. Supreme Court's *Hobby Lobby* decision and prior to the regulations that were issued under the Trump administration permitting employers to deny access to contraceptive coverage because of a religious or moral objection.

The Biden administration has also announced an interest in creating a national paid family and medical leave program. Under this program, workers would receive partial wage

[16] The ETS does not apply to workplaces covered under the contractor rule or a similar rule that applies in the healthcare context.

[17] The ETS does not apply to employees who work at a place where there are no other employees, who work from home, or who work exclusively outdoors.

[18] *BST Holdings v. OSHA*, No. 21-60845, *stay granted* (5th Cir. Nov. 6, 2021).

replacement when they take leave for a variety of reasons, including caring for an ill family member, recovering from illness, or the birth of a child.[19]

III. CONSOLIDATED APPROPRIATIONS ACT GUIDANCE

A. Surprise Medical Billing Restrictions

The No Surprises Act was adopted as part of the CAA and is effective for plan years beginning on or after January 1, 2022. The IRS, DOL, and HHS (collectively, the "Agencies") and the Office of Personnel Management ("OPM") issued two sets of interim final rules[20] providing guidance on the requirements of the No Surprises Act.

The No Surprises Act and interim final regulations apply to:

- Emergency services performed by out-of-network providers or facilities at an in-network or out-of-network facility.
- Non-emergency services performed by out-of-network providers at in-network facilities (absent the patient's informed consent, where permitted).
- Air ambulance services performed by an out-of-network provider.

The No Surprises Act prescribes how a health plan must calculate a participant's cost-sharing amount for these services. Cost-sharing payments for these services must be applied to the participant's in-network deductibles and maximum out-of-pocket limits. In addition, out-of-network providers and facilities may not "balance bill" patients for any amounts in excess of the cost-sharing amounts unless the patient has provided informed consent.

Emergency and Non-Emergency Services

A plan or insurer that covers emergency room services must do so without the need for prior authorization and regardless of whether the provider is a participating provider or facility with respect to the services. Cost sharing may not be greater than the amount that would apply if the services were provided by an in-network provider. Cost-sharing must be calculated as if the total amount that would have been charged for such services by the participating provider were equal to the "recognized amount."[21] The initial payment or denial must be made in 30 days. Affected providers cannot balance bill for amounts in excess of the cost-sharing requirement.

For non-emergency services performed by out-of-network providers at in-network facilities, cost sharing may not be greater than the amount that would apply if the services were provided

[19] As discussed in Section I.E.3 above, the BBBA currently includes paid family and medical leave provisions.

[20] 86 Fed. Reg. 36,872 (July 13, 2021); 86 Fed. Reg. 55,980 (Oct. 7, 2021).

[21] The "recognized amount" is (i) an amount determined by state law, if applicable; (ii) the amount set by the All Payer Model Agreement, if applicable for the state; or (iii) if state law does not dictate the amount, the plan's median contracted rate for the same or similar service, provided by a provider in the same or similar specialty, and in the same geographic region, as determined in accordance with HHS rules.

by a participating provider. Cost-sharing must be calculated as if the total amount that would have been charged for such services by the participating provider were equal to the "recognized amount." The initial payment or denial must be made in 30 days.

There is an exception where the provider satisfies the notice and consent requirements. To satisfy the notice requirements, the notice must be provided within a certain time frame and:

- State that the provider is nonparticipating.
- Include a good-faith cost estimate.
- If the service involves an out-of-network provider at an in-network facility, include a list of the participating providers at the facility who can furnish the services.
- Include information about whether prior authorization or other care management limitations may be required before receiving care.

The notice and consent exception is not applicable to certain "ancillary" services, including:

- Services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology.
- Certain diagnostic services (including radiology and laboratory services).
- Services for which there is no in-network provider available at the facility.
- Items and services provided by other specialty practitioners (to be determined by regulation).

External review requirements apply to adverse benefit determinations with respect to emergency services and non-emergency services provided at an in-network facility (which are further discussed below).

Impact on HSAs and HDHPs

An individual is not rendered ineligible to make HSA contributions due to surprise billing protections. In addition, an HDHP plan does not fail to be an HDHP due to compliance with surprise billing protections.

Air Ambulance Services

Cost-sharing for air ambulance services provided by an out-of-network provider cannot be greater than the cost-sharing if the services had been furnished by an in-network provider. Cost-sharing payments must be applied to the participant's in-network deductibles and maximum out-of-pocket limits. The initial payment or denial must be made in 30 days.

In September, the Agencies and OPM issued proposed regulations[22] to implement reporting requirements for air ambulance services. The proposed regulations would require plans to report to HHS certain information relating to air ambulance services provided under the plan for the 2022 and 2023 calendar years, including certain payment and claims data. If finalized, plans will be required to file the reports reflecting the required data for 2022 and 2023 by March 31, 2023, and March 30, 2024, respectively.

Dispute Resolution

Health plans must make an initial payment or deny claims of out-of-network providers and facilities that are subject to the surprise billing provisions within 30 days of receiving the claim. If the provider does not agree with the payment amount, a dispute resolution process begins with a 30-day negotiation. If the parties cannot reach a successful resolution during negotiation, the parties have four days to initiate the independent dispute resolution ("IDR") process.

The provider and payor may jointly select the IDR entity. If they do not agree on an IDR entity, or the chosen entity has a conflict of interest, then the Agencies will select the entity. IDR entities must be certified by HHS as unaffiliated with providers or payers. Each party will propose a payment amount to the IDR entity. The IDR entity must select one party's amount (and reject the other party's amount). A compromise amount is not permitted.

The IDR entity must make its decision within 30 days. When deciding, IDR entities shall not consider:

- Usual and customary charges.
- Provider or facility charges.
- Medicare, Medicaid, CHIP or Tricare rates.

In contrast, IDR entities shall consider:

- The "offer" amount, i.e., the payment amounts that the provider and payer are proposing as a settlement amount.
- Information requested by the IDR entity regarding the offer amounts.
- Information submitted by the IDR parties regarding their offer or the opposing offer.
- The "qualifying payment amount" (generally the median of the contracted rates recognized by the plan for similar services in the same geographic region).
- Information requested by the IDR entity regarding the offer amounts.

[22] 86 Fed. Reg. 51,730 (Sept. 16, 2021).

- In the case of air ambulance payment disputes, the population density of the pickup location (such as urban, suburban, rural, or frontier).

- "Additional circumstances" which include:

    - Level of training, experience, and quality and outcomes measurements of the provider.

    - Market share held by the provider or plan in the geographic region in which the service is provided.

    - Acuity of the individual receiving the service or the complexity of furnishing such service.

    - Teaching status, case mix, and scope of services of the facility.

    - Demonstrations of good-faith efforts (or lack thereof) made by the provider or plan to enter into network agreements and, if applicable, contracted rates between the provider and plan, during the previous four plan years.

The decision made by the IDR is binding on the parties and is not subject to judicial review. Payment is required in 30 days after the decision. Both parties must pay an administrative fee, and the losing party is responsible for the certified IDR entity fee for using the IDR process.[23] The party that initiates the IDR process is prohibited from taking the same party to IDR for the same service within 90 days following a decision.

There are numerous required forms, data elements, and time frames that must be followed during the IDR process.[24] A Federal IDR portal will be required to be used as part of the IDR process in certain instances, including for the selection of the IDR entities, the submission of supporting documentation to the IDR entities, and the submission of IDR entity reporting metrics.

The dispute resolution provisions are modified for air ambulance claims.

External Review Changes

Beginning January 1, 2022, the external review process applies to adverse benefit determinations related to compliance with the surprise billing and cost-sharing protections under the No Surprises Act. The regulations provide examples of the claims that would be eligible for external review. The regulations also require that grandfathered health plans (which normally

[23] The administrative fee for 2022 will be $50. In 2022, unless otherwise approved by the agencies, the IDR entity fees for a single determination may range from $200 to $500 (batched determinations may range from $268 to $670). *See* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf.

[24] *See* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act.

would not be required to follow any of the external review requirements) must provide for external review for any denied claims related to the surprise billing protections.

B. Guidance on Transparency Requirements for Group Health Plans

On August 20, 2021, the Agencies issued guidance in form of frequently asked questions ("FAQs")[25] addressing the transparency requirements for group health plans imposed under the CAA and the final transparency in coverage regulations (the "TiC Final Rules") that were issued in November of 2020.[26] The FAQs also provide guidance on the interaction of the transparency requirement provisions of the TiC Final Rules and the CAA. The TiC Final rules do not apply to "Denominational Church Plans" because the rules were issued under the Public Health Service Act ("PHSA"), which does not apply to denominational church plans. In contrast, many of the CAA provisions included amendments to the Code and, therefore, will be applicable to church plans.

1. Machine-Readable Files

The TiC Final Rules require group health plans to make price transparency information available to the public on an internet website through three machine-readable files that are updated monthly. The three files include disclosure of payment rates negotiated between plans and providers for all covered services, the allowed amount and billed charges for services provided by out-of-network providers, and pricing information for prescription drugs.

The FAQ guidance delayed enforcement of the requirement in the TiC Final Rules for prescription drug pricing until future regulations are issued. In addition, the FAQs make the enforcement of the remaining TiC requirements relating to machine-readable files for in-network rates, out-of-network allowed amounts, and billed charges effective for plan years beginning on or after July 1, 2022. These files must be posted in the first month of a plan year.

2. Price Comparison Tool

The TiC Final Rules require group health plans to make advance disclosures of the cost-sharing information specified in the regulations to participants, beneficiaries, and enrollees through an internet-based self-service tool on an internet website and in paper form upon request. This disclosure requirement is effective for plan years beginning on or after January 1, 2023, for an initial list of 500 items and services and for plan years beginning on or after January 1, 2024, for all additional items and services required to be disclosed.

The CAA requires plans to offer price comparison guidance by telephone and to make a "price comparison tool" available on the plan's website with respect to the plan year, geographic region, and participating providers. The price comparison tool must permit the comparison of the amount of cost-sharing applicable to a participant. This requirement is effective for plan years beginning on or after January 1, 2022.

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[25] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf.

[26] 85 Fed. Reg. 72,158 (Nov. 12, 2020).

The Agencies recognize that these requirements are primarily duplicative other than the addition of the requirement to offer price comparison guidance by telephone. As a result, the Agencies will likely add the telephone guidance requirement to the TiC Final Rules. In addition, the Agencies delayed the enforcement for the CAA rules until plan years beginning on or after January 1, 2023, to make the effective dates consistent.

3. Insurance Card Requirements

The CAA requires physical and electronic insurance cards issued to participants by plans to include any applicable deductibles, out-of-pocket maximum limitations, and a telephone number and website address where individuals can seek consumer assistance, such as information about in-network hospitals and urgent care centers. This provision is effective for plan years beginning on or after January 1, 2022. The Agencies do not intend to issue regulations prior to the effective date and expect plans to use a good-faith, reasonable interpretation of the law to implement the insurance card requirements. The FAQs also include an example describing an insurance card that would satisfy these requirements.

4. Good-Faith Estimates and Advance Explanation of Benefits

The CAA includes a provision requiring health care providers to provide good-faith estimates of expected charges when an individual schedules items or services or upon request. If the individual is enrolled in a health plan, then the provider must provide the good-faith estimate to the health plan. Upon receipt of the good-faith estimate, the health plan must send the individual an Advanced Explanation of Benefits notification that includes the following information:

- Whether the provider is a participating provider.
    - If participating, the contracted rate for the item or service.
    - If nonparticipating, a description of how to obtain information about participating providers.
- A good-faith estimate received from the provider.
- A good-faith estimate of the amount the plan is responsible for paying.
- A good-faith estimate of the cost-sharing for which the participant would be responsible.
- A good-faith estimate of the amount that the participant has incurred toward deductibles and out-of-pocket maximums.
- A disclaimer that the service is subject to a medical management technique (e.g., concurrent review, prior authorization, step-therapy or fail-first protocols), if applicable.
- A disclaimer that the information provided is only an estimate.

- Any other information or disclaimer the plan determines to be appropriate.

The Advanced Explanation of Benefits must be provided within one business day (or three business days, if the item or service is scheduled at least ten days before it is to be furnished).

This provision was originally effective January 1, 2022, but the FAQs delay enforcement until regulations are issued. The regulations are expected to include standards for the transfer of data between providers and plans.

5. Gag Clause Restriction on Price and Quality Data

The CAA prohibits plans from entering into agreements with providers, networks, third party administrators, or other in-network service providers that would directly or indirectly restrict the plan from:

- Providing provider-specific cost or quality of care information to a referring provider, plan sponsor, enrollee, or individual eligible to enroll.

- Electronically accessing de-identified claims and encounter information.

- Sharing information with HIPAA business associates.

The provision also requires plans to annually submit an attestation of compliance with this requirement to the Agencies. These provisions are effective December 27, 2020 (the date of the CAA's enactment).

The FAQs do not delay the effective date of this provision. Plans should use a good-faith, reasonable interpretation of the statute to implement the requirements applicable to gag clauses. The Agencies expect to issue future guidance on the attestation requirement and anticipate beginning to collect attestations in 2022.

6. Provider Directory

The CAA requires plans to establish a database of network providers and directory information. In addition, the CAA requires plans to establish a process that updates and verifies the accuracy of provider data at least quarterly. Plans must also establish a process for responding to participant requests by telephone and electronic communication about whether a provider participates in the network within one business day. If a participant is inaccurately told that an out-of-network provider participates in the network, then the plan cannot impose a cost sharing amount on those services that exceeds the in-network amount and must count the cost-sharing amounts toward any in-network deductible or out-of-pocket maximum amount. Plans are also required to post on a public website and include on Explanations of Benefits:

- Requirements and prohibitions with respect to balance billing.

- Information on contacting appropriate federal and state agencies if an individual believes those requirements and prohibitions have been violated.

This provision is applicable for plan years beginning on or after January 1, 2022. The FAQs do not delay the effective date of this provision, and plans should use a good-faith, reasonable interpretation of the statute to implement this requirement. According to the FAQs, a plan will not be deemed out of compliance if the plan treats a provider as an in-network provider for cost-sharing and out-of-pocket maximum purposes in the event inaccurate information is provided to the participant.

7. Balance Billing Notice

The CAA requires plans to make certain disclosures to participants regarding balance billing protections. The FAQs do not delay the effective date of this provision, so it remains effective for plan years beginning on or after January 1, 2022. Plans are expected to implement these requirements using a good-faith, reasonable interpretation of the requirements and may use the model disclosure provided by the Agencies to satisfy the balance billing disclosure requirements.[27]

8. Continuity of Care – Change in Provider Status

Upon a change in a provider's network status, plans and insurers are required to:

- Notify "continuing care patients" of the change.
- Provide the opportunity to notify the plan of the need for transitional care.
- Permit the patient to continue care on an in-network basis for up to 90 days.

A "continuing care patient" is a patient that is undergoing a course of treatment for a serious and complex condition, undergoing a course of institutional or inpatient care, scheduled to undergo nonelective surgery (including receiving post-op care), or determined to be terminally ill.

This provision is effective for plan years beginning on or after January 1, 2022. The FAQs do not delay the effective date of this provision. Plans must use a reasonable, good-faith interpretation of the provision in implementing this requirement.

9. Grandfathered Plans

Grandfathered plans are not subject to certain requirements under the ACA, including the requirement to cover certain preventive services without cost sharing and the annual limitation on cost sharing. The CAA does not include an exception for grandfathered health plans. Therefore, the patient protection requirements of the CAA, including the choice of provider provisions, apply to grandfathered health plans. Under the choice of provider provision, a plan must permit the selection of any available primary care provider or pediatrician. In addition, no prior authorization or referral may be required for obstetrical or gynecological care.

[27] The model notice can be found here: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-model-notice.docx.

10. Prescription Drug and Plan Spending Reporting

The CAA requires group health plans to report annually to the Agencies the following information related to prescription drugs and benefits:

- Number of enrollees.
- States of coverage.
- 50 most frequently dispensed drugs.
- 50 most costly prescription drugs and total amount spent.
- 50 prescription drugs with greatest increase in plan spending from the previous year.
- Total spending broken down by:
    - Type of costs
    - Primary and specialty care costs.
    - Prescription drug costs.
    - Other medical costs (including wellness services).
    - Spending on prescription drugs by plan and enrollees.
    - Average monthly premium paid by employer and enrollees.
    - Impact of rebates and other drug manufacturer payments.

The CAA requires plans to submit this information to the Agencies by December 27, 2021, and by June 1 of each year thereafter. The FAQs delay enforcement of this provision so that plans have until December 27, 2022, to submit the required information for 2020 and 2021.

In June, the Agencies and OPM issued a request for information[28] on the prescription drug reporting requirements included in the CAA. The CAA added parallel provisions on the reporting requirements to the PHSA, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Internal Revenue Code of 1986, as amended (the "Code"). The PHSA provision provides an express exemption for church plans whereas the Code provision does not. On July 23, 2021, the Church Alliance filed a comment letter[29] requesting that the Agencies add the same exemption for church plans to the Code. The comment letter also

[28] 86 Fed. Reg. 32,813 (June 23, 2021).

[29] *See* https://church-alliance.org/comment-letters/church-alliance-files-response-request-information-regarding-reporting-pharmacy.

describes several challenges that church plans would face if they are required to comply with this provision.

On November 17, 2021, the Agencies and the OPM issued interim final rules[30] on the reporting requirements. The preamble to the interim final rule clarifies that church plans subject to the Code are required to comply with the reporting requirements. The interim final rules also include a request for comments, which are due on January 24, 2022.

C. Mental Health Parity Nonquantitative Treatment Limitation FAQs

The CAA requires group health plans and insurers to provide to federal and state agencies – upon request – a comparative analysis of nonquantitative treatment limitations ("NQTLs") related to mental health and substance abuse disorder benefits. Generally, NQTLs are limitations on the scope or duration of benefits for treatment that are not expressed by number, such as medical management standards limiting or excluding benefits based on medical necessity.

Under the Mental Health Parity and Addiction Equity Act ("Mental Health Parity Act"), any processes, strategies, evidentiary standards, or other factors used for NQTLs in any classification for mental health and substance use disorder benefits must be comparable to, and applied no more stringently than, NQTLs for medical and surgical benefits in same classification.

Plans that provide health coverage for medical and surgical benefits and mental health and substance use disorder benefits that have any NQTLs are required to perform and document comparative analyses of NQTLs. The analysis must include specific findings and conclusions of compliance. The comparative analyses must be made available to federal and state agencies upon request beginning February 10, 2021. The Agencies are required to request at least 20 comparative analyses per year from different group health plans and health insurance issuers.

On April 2, 2021, the Agencies issued FAQs[31] on the mental health parity NQTL provision of the CAA. The FAQs provide that a general statement of compliance and conclusory references are not sufficient. In addition, the large production of documents without clear descriptions and relevant analysis is not sufficient. If a plan carefully applies the guidance in the Self-Compliance Tool, then the FAQs state that the plan is in a "strong position" for compliance.

If the Agencies conclude the comparative analysis provided is not sufficient or compliant, then the plan must specify the actions it will take to make the analysis compliant and provide a follow-up corrected comparative analysis within 45 days. The second review by the Agencies is the final determination and, if the Agencies again determine the plan is noncompliant, then the plan is required to notify all enrollees of noncompliance with the Mental Health Parity Act within 7 days.

The Agencies have broad discretion to request NQTL comparative analyses in any situation. For example, the Agencies may request a comparative analysis from a plan if they

[30] 86 Fed. Reg. 66,495 (Nov. 23, 2021).

[31] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf.

receive a complaint of a prior authorization requirement for prescriptions to treat opioid use disorders.

The FAQs also state that the DOL expects to focus on the following NQTLs in its enforcement efforts in the "near term":

- Prior authorization requirements for in-network and out-of-network inpatient services.
- Concurrent review for in-network and out-of-network inpatient and outpatient services.
- Standards for provider admission to participate in a network, including reimbursement rates.
- Out-of-network reimbursement rates (i.e., plan methods for determining usual, customary, and reasonable charges).

State regulators may request NQTL comparative analyses. Claimants (or their authorized representatives) may also request comparative analyses, free of charge, upon the appeal of a denied claim or a final internal adverse decision, if relevant to claim.[32]

D. FSA Guidance

The CAA expands the relief issued by the IRS in 2020 that was intended to allow employees additional flexibility to use funds in health and dependent care FSAs. Specifically, the CAA permits (but does not require) employers to elect to offer the following:

- Carryover of an unlimited amount of unused funds from the plan years ending in 2020 and 2021 to the following year.
- Extended maximum grace period from three to 12 months for plan years ending in 2020 or 2021.
- Post-termination reimbursements from health care FSAs for employees who terminate employment during 2020 or 2021 until the end of the plan year in which the termination occurs or any applicable grace period.
- Increase in the age limit from 13 to 14 for dependent care FSAs for dependents who aged out during the pandemic but only with respect to amounts contributed during the plan year where the enrollment period ended on or before January 31, 2020.
- FSA change in election amount without a qualifying status change event for plan years ending in 2021.

[32] Plans subject to ERISA must, upon request, provide NQTL comparative analyses to participants, beneficiaries, or enrollees (or their authorized representative).

In Notice 2021-15, the IRS provided additional guidance and clarification on the CAA provisions allowing additional FSA flexibility. In particular, the notice provides guidance on carryovers, grace periods, the interaction between carryovers and grace periods, HSA compatible FSAs, post-termination reimbursements from health care FSAs, relief for dependent care FSA expenses for certain dependents who aged out during the pandemic, and certain FSA election changes. Among many other changes and clarifications, the notice permits employers to amend health, dental, and vision plans for the plan year ending in 2021 to allow employees to:

- Make a new election on a prospective basis, if the employee initially declined to enroll.

- Revoke an existing election and make a new election to enroll in different health coverage sponsored by the same employer on a prospective basis.

- Revoke an existing election on a prospective basis, provided the employee attests in writing that he or she is enrolled, or immediately will enroll, in other health coverage not sponsored by the employer.

Plan amendments to implement the temporary relief permitted under the CAA and the notice can be retroactive if:

- Adopted no later than the last day of the calendar year beginning after the end of plan year in which the amendment is effective, and

- The plan is administered consistent with any change.

For example, a calendar year plan that allowed increased carryover amounts from 2020 into 2021 would require an amendment by December 31, 2021.[33]

E. Qualified Disaster Relief Distributions

The CAA also includes a provision permitting qualified disaster relief distributions from certain retirement plans. This relief applies for disasters that occur during the period beginning on or before December 28, 2019, and ending on or before December 27, 2020, and that have been declared disasters by the President under the Stafford Disaster Relief and Emergency Assistance Act from January 1, 2020, through February 25, 2021.

Under this provision, eligible retirement plans and IRAs may permit affected individuals to take a qualified disaster distribution of up to $100,000 without being subject to the 10% additional tax on early distributions. The distribution may be included in the individual's income ratably over a three-year period. In addition, the CAA permits the individual to repay the qualified disaster distribution within three years of receiving it by making one or more contributions to an eligible retirement plan or IRA. To be eligible for a qualified disaster

[33] The IRS also issued guidance clarifying the taxability of amounts attributable to carryovers or extended periods for incurring claims under dependent care FSAs. In Notice 2021-26, the IRS clarified that dependent care benefits that would have been excluded from income if used during 2020 or 2021, as applicable, will remain excludable from gross income for 2021 and 2022.

distribution, an individual must have a principal place of abode in a qualified disaster area during the incident period and have suffered an economic loss because of the qualified disaster.

The CAA also permits eligible individuals to repay by June 25, 2021, hardship distributions that were taken to purchase or construct a home in a qualified disaster area but that were not used because of the qualified disaster.

Employers have until the last day of the first plan year beginning on or after January 1, 2022, to adopt plan amendments to permit qualified disaster distributions or the repayment of hardship distributions because of a qualified disaster.

IV. AMERICAN RESCUE PLAN GUIDANCE

A. Premium Assistance for COBRA Benefits

On March 11, 2021, President Biden signed into law the American Rescue Plan Act ("ARPA"), which contains a COBRA premium subsidy. The COBRA subsidy provision requires employers to cover 100% of the cost of COBRA continuation coverage from April 1, 2021, through September 30, 2021, for employees who lost coverage because of a reduction of hours or involuntary termination. The subsidy is also available for health coverage provided under comparable state continuation coverage laws. The COBRA subsidized coverage will end on the earlier of September 30, 2021, the date the individual's regular 18-month COBRA continuation period ends, or the date the individual becomes eligible for coverage under another group health plan or Medicare.

Employers may recover the cost of the premium subsidy through a payroll tax credit against the employer portion of Social Security and Medicare taxes. The credit is equal to the premium charged to the eligible individual in the absence of ARPA.

To be eligible, at least a portion of the individual's potential 18-month COBRA coverage period must fall between April 1, 2021, and September 30, 2021. Accordingly, the COBRA subsidy applies to certain individuals who elected COBRA prior to April 1, 2021, and to individuals who first become eligible for COBRA during this time period. The COBRA subsidy also applies to certain individuals who failed to elect COBRA or elected and then dropped COBRA coverage prior to April 1, 2021.

An eligible individual is not required to enroll in the same plan option to receive subsidized coverage. Instead, an employer is permitted to allow eligible individuals to enroll in a different plan option if the premium is no higher than the premium applicable under the employee's prior plan option.

ARPA also requires plan administrators to update or provide several notices relating to the subsidy. Specifically, ARPA includes the following notice requirements:

- The standard election notice must be updated to include information about the COBRA subsidy for individuals who become eligible for COBRA between April 1, 2021, and September 30, 2021.

- A new notice must be provided to individuals who became eligible for COBRA before April 1, 2021, and whose COBRA-coverage period ends after such date, to inform them that they can elect subsidized coverage. This notice was required to be provided by May 31, 2021, and individuals had 60 days after the notice was provided to elect COBRA.

- A notice must be provided to individuals 15 to 45 days before the premium assistance ends to inform them when the premium subsidy is ending and of other coverage options that may be available.

On April 7, 2021, the DOL issued answers to FAQs[34] related to the COBRA subsidy along with model notices.[35] The IRS has also issued two notices providing guidance on the COBRA subsidy requirements. Notice 2021-31 provides guidance in the form of 86 questions and answers ("Q&As"), and Notice 2021-46 addresses additional issues through 11 more Q&As.

B. Increase in Dependent Care FSA Maximum

For 2021, ARPA increases the dependent care FSA maximum for the 2021 calendar year to $10,500 (or $5,250 for married participants filing separately). If a plan amendment is necessary to implement this provision,[36] then the amendment must be made by the last day of the plan year in which the amendment is effective, and the plan must be operated in accordance with the terms of the amendment beginning on the effective date of the amendment.[37]

V. COVID-19 RELATED GUIDANCE

A. Extended Participant and Plan Deadlines

On February 26, 2021, the DOL issued Notice 2021-01[38] to extend the relief issued in 2020 with respect to certain benefit plan deadlines. The relief requires benefit plans to disregard the "Outbreak Period" when determining if certain participant deadlines and time periods have been satisfied. Under the new notice, the deadline extension applies on a person-by-person basis

[34] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-premium-assistance-under-arp.pdf.

[35] *See* https://www.dol.gov/cobra-subsidy.

[36] A plan amendment may not be required if the plan language automatically provides an increase by incorporating the amount permitted under the applicable Code section. In contrast, a plan amendment would be required if the plan language limits the maximum to a specific dollar amount or if the increase is not desired, but the plan document incorporates the amount permitted under the applicable Code section.

[37] Notice 2021-26 provides additional guidance on the taxability of dependent care FSA benefits for non-calendar year plans adopting an increased dependent care FSA maximum for the 2021 plan year that begins in 2021 and ends in 2022. The increased exclusion amount of $10,500 only applies to the 2021 calendar year. In certain cases, this will result in taxable income if part of the employee's contribution for the 2021 plan year is used to reimburse expenses incurred during 2022 and the total amount of expenses reimbursed in 2022 exceeds $5,000 (the standard exclusion amount for dependent care FSAs).

[38] The Department of Treasury, IRS, and HHS concur with this guidance.

until the earlier of 60 days after the announced end of the COVID-19 national emergency, or one year from when the person was first eligible for the relief.

The relief applies to:

- HIPAA special enrollment.
- COBRA elections.
- COBRA qualifying event and disability notices.
- Initial and monthly COBRA payments.
- Claim and appeal deadlines.
- External review deadlines.

The presidentially-declared "national emergency" regarding COVID-19 is ongoing. On March 13, 2020, President Trump declared a "national emergency" with respect to COVID-19 effective as of March 1, 2020. President Biden continued the "national emergency" through a declaration on February 24, 2021.

Notice 2021-01 also discusses potential participant communications that plans should "consider," including sending a notice to individuals who may be losing coverage to inform them about other coverage options that may be available to them (e.g., Marketplace coverage) and updating prior communications regarding the Outbreak Period to reflect the new guidance included in the notice.

B. FAQ Guidance

1. COVID-19 Testing, Preventive Services, Summary of Benefits and Coverage Relief, and Excepted Benefits

On February 26, 2021, the Agencies issued FAQ guidance[39] addressing implementation of the Families First Coronavirus Response Act ("Families First Act"),[40] the CARES Act, and other health coverage issues related to COVID-19.[41] The FAQs provide guidance on COVID-19 diagnostic testing, coverage of preventive services for COVID-19, summary of benefits and coverage ("SBC") relief, and excepted benefits. The Agencies also issued an FAQ on October 4, 2021, clarifying the preventive services guidance included in the February 26th FAQs and providing guidance on vaccine mandates and incentives under wellness programs (which is further discussed in Section V.B.2 below).

[39] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-44.pdf.

[40] Public Law No. 116-127 (2020).

[41] Public Law No. 116-136 (2020).

- COVID-19 Diagnostic Testing. The FAQs provide the following guidance on the requirement to cover certain items and services related to COVID-19 diagnostic testing without cost-sharing, prior authorization, or other medical management requirements:

    - Plans may not deny or impose cost sharing on a claim for a COVID-19 diagnostic test for an asymptomatic person who has no suspected exposure to COVID-19.

    - Plans are not required to provide coverage of testing for public health, employment, or other purposes not primarily intended for individualized diagnosis or treatment of COVID-19.

    - Plans are required to cover COVID-19 diagnostic testing provided through a state- or locality-administered testing site and point-of-care (i.e., rapid) tests for COVID-19.

    - The Agencies provide an email address for plans to report providers who violate the cash price posting requirements.[42]

- Coverage of Preventive Services for COVID-19. The FAQs provide guidance on the requirement for a plan to cover without cost sharing COVID-19 preventive services and vaccines within 15 days of receiving a recommendation that makes them a "qualifying coronavirus preventive service":

    - Non-grandfathered health plans must cover without cost-sharing all COVID-19 vaccines that have a recommendation in effect.

    - Plans are required to cover administration of the vaccine even if a third party (such as the Federal Government) pays for the vaccine itself.

    - A plan cannot deny coverage of COVID-19 vaccines if an individual is not in a category recommended for early vaccination by state and local jurisdictions. If a provider declines to provide a vaccine for this reason, the provider's decision is not subject to the plan's claims procedures.

    - The requirement for plans to cover COVID-19 vaccines became effective January 5, 2021, which is 15 business days after the recommendation was adopted by the Centers for Disease Control. Accordingly, plans must now cover, without cost sharing, any COVID-19 vaccine authorized under an emergency use authorization or approved under a biologics license application, immediately upon authorization or approval.

[42] The CARES Acts included a requirement that providers make public the cash price for COVID-19 diagnostic testing on a public website. The Agencies issued interim final regulations providing additional guidance on this requirement in November of 2020.

- SBC Relief. Plans are generally required to provide advance notice of any modification to the SBC no later than 60 days prior to the effective date of the modification. The Agencies will not take enforcement action against a plan that fails to comply with the advance notice requirement for the coverage of qualifying coronavirus preventive services. However, a plan must provide notice of the change as soon as reasonably practicable.

- Excepted Benefits. The FAQs clarify that an employer may offer COVID-19 vaccines under an employee assistance program ("EAP") that is considered an excepted benefit if there is no cost sharing and the EAP complies with other applicable requirements. An employer may also offer COVID-19 vaccines at an on-site medical clinic that constitutes an excepted benefit.

2. Vaccine Surcharges and Incentives Under Wellness Programs

HIPAA generally prohibits plans from discriminating against participants in eligibility, premiums, or contributions based on a health factor. There is an exception to this general prohibition for premium discounts, rebates, or modifications of cost-sharing requirements under a wellness program. There are several different types of wellness programs, including activity-only wellness programs.[43]

On October 4, 2021, the Agencies issued FAQs[44] to provide guidance on whether group health plans can provide incentives to encourage individuals to receive COVID-19 vaccines. The FAQs permit group health plans to offer participants a premium discount for receiving a COVID-19 vaccine, if it complies with the requirements applicable to activity-only wellness programs. Among other requirements, an activity-only wellness program must satisfy the following requirements:

- The program must be reasonably designed to promote health or prevent disease.

- A reasonable alternative must be provided to obtain the reward for individuals for whom it is unreasonably difficult or medically inadvisable to receive the COVID-19 vaccine due to a medical condition.[45]

- The program must disclose the availability of the alternative in all plan materials describing the wellness program.

- The reward (when added to all other health-contingent wellness program rewards) cannot exceed 30% of the total cost of employee-only coverage under the plan and the opportunity to qualify for the reward must be given at least annually.

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[43] An activity-only wellness program requires an individual to perform an activity related to a health factor (e.g., obtaining a vaccine) to obtain a reward.

[44] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf.

[45] For example, the FAQs state that a wellness program could offer a waiver from the vaccine or the right to attest to following other COVID-19-related guidelines, such as the mask guidelines for unvaccinated individuals.

While a group health plan may offer participants a premium discount for receiving a COVID-19 vaccine, the plan is prohibited from conditioning eligibility for benefits or coverage for otherwise eligible services on participants being vaccinated. A plan must uniformly apply any restriction on benefits to all similarly situated individuals and may not impose a restriction on an individual based on a health factor.

The FAQs also provide guidance on how premium discounts and surcharges for COVID-19 vaccines are treated for purposes of determining the affordability of coverage under the employer shared responsibility rules. A premium discount for receiving a COVID-19 vaccine is disregarded for purposes of determining whether an offer of coverage is affordable. In contrast, a surcharge imposed on an unvaccinated individual would not be disregarded in determining affordability.

C. FSA, HRA, and HSA Guidance

The CARES Act permits FSA, HSA, and health reimbursement arrangement ("HRA") to reimburse expenses for over-the-counter drugs and menstrual care products that are incurred on or after January 1, 2020. In Notice 2021-15, the IRS permitted retroactive amendments for reimbursements of these items for any period beginning on or after January 1, 2020.

In Announcement 2021-7, the IRS states that amounts paid for personal protective equipment for the primary purpose of preventing the spread of COVID-19 (e.g., masks, hand sanitizer, and sanitizing wipes) are eligible for reimbursement under FSAs, HSAs, and HRAs. If a plan amendment is needed to implement this change, the announcement permits retroactive plan amendments on or before December 31, 2022, if the amendment is adopted by the last day of first calendar year beginning after end of plan year in which the change is effective. Prospective amendments are required after December 31, 2022. The plan also must be operated consistently with the amendment for the period starting on the effective date.

The IRS also reminded taxpayers in IR 2021-181 that the cost of home COVID-19 testing is a medical expense eligible for reimbursement under health FSAs, HSAs, and HRAs.

D. EEOC Vaccine Incentive and Mandate Guidance

On May 28, 2021, the EEOC updated technical assistance[46] providing guidance on when an employer can offer an incentive to employees to obtain a COVID-19 vaccine. The technical assistance only applies to federal equal employment opportunity ("EEO") laws, such as the Americans with Disabilities Act ("ADA") and the Genetic Information Nondiscrimination Act ("GINA"), and not to other federal, state, and local laws. Importantly, the updated technical assistance provides that:

- Employers may require all employees physically entering the workplace to be vaccinated for COVID-19 if they provide reasonable accommodations to

[46] *See* https://www.eeoc.gov/newsroom/eeoc-issues-updated-covid-19-technical-assistance and https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=. .

employees who have a disability or sincerely held religious belief that prevent them from being vaccinated.

- Employers may offer incentives to employees to voluntarily provide proof of COVID-19 vaccination obtained from a third party (not the employer) if the vaccination information is kept confidential under the ADA.

- Employers that are administering vaccines to employees may offer incentives to their employees to be vaccinated, if they are not so substantial as to be coercive.

- Employers may provide employees and their families with educational information about COVID-19 vaccines and the benefits of vaccination.

As new developments occur with respect to COVID-19, the EEOC will consider any impact they have on the EEOC's technical assistance and will provide updates as needed.

E. Employee Retention Credit Guidance

The CARES Act allows eligible employers that pay qualified wages to employees to claim a credit, known as the employee retention credit, against applicable employment taxes for the period beginning March 12, 2020, and ending January 1, 2021. The CAA extended the application of the employee retention credit to qualified wages paid after December 31, 2020, and before July 1, 2020, and modified the calculation of the credit amount for wages paid during that period. ARPA further extended the coverage period for the employee retention credit to include qualified wages paid through December 31, 2021. The IIJA then provided for the early termination of the employee retention credit as of September 30, 2021, subject to a limited exception.

The IRS issued Notices 2021-20 and 2021-49 to provide additional guidance on the employee retention credit and the changes made by the CAA and ARPA.

F. Church Alliance Letter Urging COVID-19 Relief Legislation

On December 15, 2020, the Church Alliance sent letters[47] to the U.S. House of Representatives and the Senate urging leadership to approve a COVID-19 relief package. Specifically, the letters encouraged Congress to extend the Paycheck Protection Program and the Employee Retention Tax Credit, provide churches with COVID-19 liability protection and tax incentives to help offset the costs of modifications to the workplace, and extend to church plans any relief provided for employer-provided health plans, such as health care continuation coverage for employees who lost their jobs.

[47] *See* https://church-alliance.org/legislation/church-alliance-urges-congress-approve-relief-package.

VI. REGULATORY GUIDANCE AND OTHER INITIATIVES IMPACTING RETIREMENT PLANS

A. Internal Revenue Service

1. 403(b) and 401(k) Pre-Approved Plan Guidance

In 2013, the IRS began accepting applications for approval of the form of 403(b) prototype and volume submitter plans. The IRS issued opinion and advisory letter for these plans in 2017. Eligible employers were required to adopt the pre-approved documents by June 30, 2020, which is the end of the initial Remedial Amendment Period ("RAP") provided for under the IRS revenue procedure instituting the 403(b) pre-approved plan program. In 2019, the SECURE Act clarified that both qualified church-controlled organizations ("QCCOs") and non-QCCOs can participate in section 403(b)(9) plans.

In September, the IRS issued Revenue Procedure 2021-37, which sets forth the IRS's procedures for issuing opinion letters to 403(b) pre-approved plans in Cycle 2 of the program. Importantly, the revenue procedure makes the following changes, some of which are intended to align the procedures applicable to the 403(b) pre-approved plan program with those applicable to the 401(a) pre-approved plan program:

- Eliminates the distinction between 403(b) prototype and volume submitter plans.
- States that the IRS will issue a cumulative list of changes in the 403(b) requirements that are required to be added to 403(b) plan documents.
- Permits the submission of a Form 5307 application for a determination letter during a certain time period by: (1) an adopting employer of a nonstandardized 403(b) plan that makes plan amendments that are not extensive; or (2) an adopting employer of any 403(b) pre-approved plan that adds language to satisfy the requirement of Code Section 415 because of the required aggregation of plans.
- Provides guidance on the RAPs that follow the initial RAP.
- Provides that the filing period for 403(b) pre-approved plans for Cycle 2 will begin May 2, 2022, and end May 1, 2023.
- Permits nonstandardized plans to permit either safe harbor or non-safe harbor hardship distributions.
- Establishes an interim amendment deadline for non-governmental 403(b) pre-approved plans of the end of the second calendar year following the calendar year in which the 403(b) requirement is effective.
- If an interim amendment is timely made, provides that the RAP for amendments to correct form defects first occurring after June 30, 2020 ends on the later of: (1) the end of the cycle that includes the date on which the RAP would have ended if the plan were an individually-designed plan; or (2) the end of the first cycle in

which an application for an opinion letter that considers the form defect may be submitted.

- Provides guidance on a limited extension of the initial RAP for certain form defects first occurring during Cycle 1.

The revenue procedure also provides guidance on permitting QCCOs and non-QCCOs to participate in a 403(b)(9) pre-approved plan. Specifically, a pre-approved plan may permit the participation of employees of QCCOs and non-QCCOs in a 403(b)(9) retirement income account plan by making a good-faith plan amendment retroactive to the beginning of Cycle 2 (i.e., July 1, 2020). In addition, non-QCCO employers will have until the end of the Cycle 2 employer adoption window to adopt a 403(b) plan permitting the participation of non-QCCO employees and stating that the Code Section 403(b)(12) nondiscrimination requirements will apply to employees of non-QCCOs. Finally, adopting employers must indicate whether they are a church, QCCO, or non-QCCO.

On the same date the IRS released Revenue Procedure 2021-37, the IRS also released Revenue Proceure 2021-38 to provide guidance on 401(a) pre-approved plan amendments. Under this revenue procedure, the IRS modifies the deadline for adopting an interim amendment for a section 401(a) pre-approved plan so it matches the deadline for adopting an interim amendment for a section 403(b) pre-approved plan. Accordingly, an interim amendment for both a 401(a) and 403(b) pre-approved plan is the end of the second calendar year following the calendar year in which the requirement is effective.

2. EPCRS Update

On July 20, 2021, the IRS issued Revenue Procedure 2021-30 to update the Employee Plan Compliance Resolution System ("EPCRS"), which is the IRS correction program for retirement plans sponsors. EPCRS consists of three different types of correction programs: the self-correction program ("SCP"), the voluntary correction program ("VCP"), and the audit closing agreement program ("Audit CAP"). The primary changes made by the revenue procedure are:

- Increasing the de minimis threshold for the return of overpayments and distribution of "excess amounts" from $100 to $250.

- Exempting corrective distributions of $75 or less.

- Adding flexibility for the correction of overpayments.

- Extending the availability of SCP by:

    - Extending the time to self-correct significant operational failures to the end of third plan year after the failure occurred.

    - Expanding the availability of the retroactive amendment correction.

- Extending the missed deferral correction for automatic contribution plans to December 31, 2023.

The IRS also eliminated the anonymous submission procedure as of January 1, 2022, and replaced it with a pre-submission conference option. The pre-submission conference option is subject to IRS discretion and is advisory only and not binding on IRS. Under the pre-submission conference option, the IRS will provide oral feedback about failures and proposed corrections.

3. Postponement of Certain Tax Deadlines After Federally Declared Disasters

The IRS will postpone certain retirement plan deadlines for affected taxpayers in the event of a presidentially-declared disaster, which often includes severe storms (e.g., tornados and hurricanes), wildfires, floods, or earthquakes. An affected taxpayer is generally a person who lives in or has a business in an area impacted by the disaster.

After a disaster is declared, the IRS will issue a news release describing the type of relief, the eligible taxpayers, and the relief period. Section 8 of Revenue Procedure 2018-58 lists the retirement plan deadlines that the IRS may postpone. If the news release for a disaster does not limit the relief, then all of the deadlines listed in the revenue procedure will be postponed.[48]

The IRS issued several news releases over the past year providing tax relief for certain disasters. The news releases are listed on the IRS's website.[49]

In June, the IRS issued final regulations[50] providing guidance on Code section 7508A(d), which was added by legislation enacted at the end of 2019. Subsection (d) of section 7508A requires Treasury to automatically postpone for a minimum of 60-days certain federal tax deadlines for individuals affected by federally-declared disasters that occur on or after December 20, 2019. The automatic extension also applies to the deadline for making contributions to a qualified retirement plan, completing rollovers, withdrawing excess IRA contributions, and recharacterizing IRA contributions. In addition to the automatic extension, Code section 7508A(a) gives the IRS discretionary authority to postpone deadlines as the result of a federally-declared disaster.

The final regulations include provisions that provide:

- Extensions are not automatic; instead, the IRS must specify the deadlines that are postponed.
- If the IRS does not postpone any deadlines in response to a federally-declared disaster, then no deadlines are subject to the 60-day extension.
- If an incident date is not declared for a federal disaster, then the 60-day automatic extension period does not apply.

[48] *See* https://www.irs.gov/retirement-plans/disaster-relief-for-retirement-plans-and-iras.

[49] *See* https://www.irs.gov/newsroom/tax-relief-in-disaster-situations.

[50] 86 Fed. Reg. 31,146 (June 11, 2021).

- The 60-day period runs concurrently with any discretionary extensions specified by the IRS; if the discretionary extension ends first, then the extension will continue until 60 days after the latest incident date, provided a deadline is extended for no more than one year.

- The final regulations also clarify the definition of "federally declared disaster."

The provisions clarifying the definition of "federally declared disaster" are effective June 11, 2021. The remaining regulations are applicable for disasters declared on or after December 21, 2019.

4. Extension of In-Person Notarization Requirements

In response to the COVID-19 public health emergency, the IRS provided temporary relief from the physical presence requirement in Treasury regulation section 1.401(a)-21(d)(6) for certain participant elections, including spousal consent required under Code section 417. In Notices 2021-3 and 2021-40, the IRS extended the physical presence requirement relief to June 30, 2022. Provided the applicable requirements set forth in the notices are satisfied, the temporary relief from the physical presence requirement applies to participant elections that are witnessed by either: (i) a plan representative; or (2) a notary public of a state that permits remote electronic notarization

5. Final Regulations on Qualified Plan Loan Offsets

In January 2021, the IRS issued final regulations[51] on the extended rollover period for a qualified plan loan offset ("QPLO"), which was permitted by the Tax Cuts and Jobs Act. The final regulations adopt the proposed regulations with only one modification to delay the applicability date.

A QPLO is defined as a plan loan offset amount that is treated as distributed from a qualified employer plan to an employee or beneficiary solely because of (1) the termination of the qualified plan; or (2) the failure to meet the repayment terms of a plan loan because of a severance from employment with the employer.

A plan loan offset generally must be rolled over to an eligible retirement plan within 60 days of the date of the offset. In contrast, a QPLO can be rolled over at any time up to the participant's income tax filing deadline (including extensions) for the taxable year in which the loan offset is treated as distributed.[52]

The final regulations state that QPLO amounts are subject to most of the same rules applicable to rollovers of other plan loan offsets, provide guidance on the rollover period applicable to QPLOs, set forth definitions for important terms, establish a standard for

[51] 86 Fed. Reg. 464 (Jan. 6, 2021).

[52] The final regulations clarify that distributees who do not request an extension of the income tax filing deadline may be treated as though they had requested an extension for purposes of the rollover deadline if certain requirements are satisfied.

determining when a plan loan offset has been distributed because of a severance from employment, and provide several examples illustrating these rules. The regulations apply to plan loan offset amounts, including qualified plan loan offsets, treated as distributed on or after January 1, 2021.

6. SECURE Act Guidance for Safe Harbor Plans

The SECURE Act eliminated the annual safe harbor notice for safe harbor plans that utilize nonelective safe harbor contributions (rather than safe harbor matching contributions) and adds new provisions for the retroactive adoption of safe harbor status for those plans. For plans that utilize the automatic enrollment safe harbor design (qualified automatic contribution arrangements, or QACAs), the SECURE Act also changed the maximum percentage to which an automatic deferral can be increased from 10% to 15%, other than for the first year of participation.

The IRS issued Notice 2020-86 to provide guidance on certain issues while the Treasury Department and IRS develop regulations to fully implement these provisions of the SECURE Act. The guidance in the notice is provided in the form of 13 Q&As.

7. Required Amendments List and Operational Compliance List

The IRS publishes a required amendments list annually now that the 5-year remedial amendment cycle for individually-designed plans has been discontinued. Plan sponsors will generally be required to adopt an item on the required amendment list by the end of the second calendar year following the year the required amendments list is published. The IRS has a webpage that provides links to required amendment lists from previous years and the amendment deadlines set forth therein.[53]

The amendments listed on the 2019 required amendment list must be adopted by December 31, 2021 (i.e., the end of the second calendar year following the year the required amendments list is published). The 2019 required amendments list included in Notice 2019-64 listed the final regulations relating to hardship distributions and the final regulations regarding cash balance and hybrid defined benefit plans. Accordingly, plans are required to be amended by December 31, 2021, for these changes.

In addition, employers maintaining pre-approved defined contribution plans (e.g., a pre-approved 401(k) or profit-sharing plan) must adopt the restated plan document prepared by the provider no later than July 31, 2022. Finally, SECURE Act and CARES Act amendments must generally be adopted no later than the last day of the first plan year beginning on or after January 1, 2022.

The IRS also provides an "Operational Compliance List"[54] on its website. The Operational Compliance List is updated periodically and identifies changes in qualification

[53] See https://www.irs.gov/retirement-plans/required-amendments-list.

[54] The Operational Compliance List is available at the following website only and will not be published in an Internal Revenue Bulletin: https://www.irs.gov/retirement-plans/operational-compliance-list.

requirements and Code section 403(b) requirements effective during a calendar year. This list is helpful for plan sponsors to achieve operational compliance even before required amendments are adopted by plans. It may also be a helpful tool to identify mandatory and discretionary plan amendments as well as other significant guidance that impacts daily plan operation.

8. Retirement Plan Limits for 2022

The cost-of-living and required statutory limit adjustments applicable to retirement plans for 2022 are as follows:[55]

Contribution limit for defined contribution plan under Code § 415(c)	**$61,000** (*$3,000 increase*)
Benefit limitation for defined benefit plan under Code § 415(b)	**$245,000** *($15,000 increase)*
Elective deferral limit under Code § 402(g)	**$20,500** *($1,000 increase)*
Age 50 catch-up contribution limit under Code § 414(v)	**$6,500** *(unchanged)*
Age 50 catch-up contribution limit for SIMPLE plan	**$3,000** (*unchanged*)
Contribution limit for a Code § 457(b) eligible deferred compensation plan	**$20,500** (*$1,000 increase)*
Annual compensation limit under Code § 401(a)(17)	**$305,000** (*$15,000 increase)*
HCE compensation definition dollar threshold[56]	**$135,000**[57] *($5,000 increase)*
Dollar threshold limitation for key employee determination in top-heavy plan	**$200,000** *($15,000 increase*)
Contribution limit for a SIMPLE retirement plan	**$14,000** *($500 increase)*
Participant compensation eligibility amount under Code § 408(k)(2)(C) for simplified employee pension (SEP) employer contributions	**$650** *(unchanged)*

B. Department of Labor

This section of the report focuses on DOL guidance issued over the last year under ERISA. The guidance in this section does not apply to plans that are not subject to ERISA, such as non-electing church plans, but may provide useful information to and suggest "best practices" for such plans.

[55] Notice 2021-61.

[56] The definition of highly compensated employee, or HCE, is also used in several welfare plan nondiscrimination tests.

[57] For the 2022 plan year, an employee who earns more than $130,000 in 2021 is an HCE. For the 2023 plan year, an employee who earns more than $135,000 in 2022 is an HCE.

1. DOL Final Rule on Proxy Voting

On December 11, 2020, the DOL issued final regulations[58] amending the "investment duties" regulations to provide guidance for plan fiduciaries to follow when they exercise shareholder rights, including proxy voting. The final regulations included several changes to the proposed regulations. In March, the DOL announced that it will not enforce the final rule.[59]

2. Proposed ESG Investment Regulations

In 2020, under the Trump administration, the DOL issued a final rule[60] amending the "investment duties" regulation under ERISA to require plan fiduciaries to select investments and investment courses of action based solely on "pecuniary" factors. When choosing investments, the regulations only allow plan fiduciaries to use "non-pecuniary" factors if the fiduciary is unable to decide on an investment using pecuniary factors alone. Examples of "nonpecuniary" factors include environmental, social, and governance ("ESG") factors.

In March, the DOL announced that it will not enforce the final rule.[61] The Biden administration issued an Executive Order[62] in May that directed the Secretary of Labor to consider publishing a proposed rule "to suspend, revise, or rescind" the rules finalized in 2020 by the previous administration.

On October 13, 2021, the DOL issued proposed regulations[63] that would amend the 2020 regulations governing the selection of retirement plan investments. Among other changes, the proposed regulations require fiduciaries to use a risk-return analysis in selecting investments instead of considering "pecuniary" factors. When selecting investments, the proposed regulations permit fiduciaries to consider any factor that is material to the risk-return analysis, including climate change-related factors and other ESG factors.

3. DOL Final Prohibited Transaction Exemption

ERISA includes prohibited transaction provisions that generally prohibit plan fiduciaries from receiving compensation in transactions involving ERISA plans. On December 18, 2020, the DOL issued a final prohibited transaction exemption, known as Prohibited Transaction Exemption ("PTE") 2020-02,[64] that would permit investment advice fiduciaries to receive

[58] 85 Fed. Reg. 81,658 (Dec. 16, 2020).

[59] *See* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/erisa/statement-on-enforcement-of-final-rules-on-esg-investments-and-proxy-voting.pdf.

[60] 85 Fed. Reg. 72,846 (Nov. 13, 2020).

[61] *See* https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/erisa/statement-on-enforcement-of-final-rules-on-esg-investments-and-proxy-voting.pdf.

[62] *See* https://www.whitehouse.gov/briefing-room/presidential-actions/2021/05/20/executive-order-on-climate-related-financial-risk/.

[63] 86 Fed. Reg. 57,272 (Oct. 14, 2021).

[64] 85 Fed. Reg. 82,798 (Dec. 18, 2020). The preamble to the final regulations also includes a discussion of the DOL's current interpretation of the five-part test for determining when a person is an investment advice fiduciary under ERISA.

compensation for investment advice that would otherwise violate the prohibited transaction rules, including both rollover advice and advice on how to investment assets within a plan or IRA. Among other requirements, PTE 2020-02 requires fiduciaries to provide investment advice in accordance with three "impartial conduct standards." Under these standards, fiduciaries would be required to provide investment advice that is in the best interest of the investor, accept no more than reasonable compensation, and make no materially misleading statements.

PTE 2020-02 was effective February 16, 2021 but is subject to the temporary enforcement policy set forth in Field Assistance Bulletins 2018-02 and 2021-02.[65] Under these bulletins, the DOL will not pursue prohibited transaction claims: (i) for the period prior to January 31, 2022 against investment advice fiduciaries who are working diligently and in good faith to comply with PTE 2020-02; and (ii) for the period prior to June 30, 2022 against investment advice fiduciaries who are otherwise in compliance with PTE 2020-02 other than the disclosure and documentation requirements.

In April, the DOL also issued FAQs[66] on PTE 2020-02 and the DOL's interpretation of the five-part test for determining who is an investment advice fiduciary under ERISA. In addition to reiterating the requirements applicable to PTE 2020-02 and five-part test, the FAQs include new guidance on several issues and state that the DOL intends to take further regulatory and sub-regulatory actions, including amending the existing fiduciary investment advice regulations, PTE 2020-02, and some of the other existing class exemptions available to investment advice fiduciaries.

4. Missing Participant Guidance

On January 12, 2021, the DOL issued a document providing best practices for retirement plans with missing participants. This document sets forth and provides guidance on certain practices that have been effective in mitigating the problem of missing participants, including: (1) maintaining accurate census data for the plan's participants; (2) implementing effective communication strategies; (3) conducting missing participant searches; and (4) documenting procedures and actions.[67]

[65] *See* https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2021-02.

[66] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/new-fiduciary-advice-exemption. A consumer-focused guide was issued along with the FAQs to provide a list of questions investors in retirement plans and IRAs should consider asking before relying on investment advice. *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/choosing-the-right-person-to-give-you-investment-advice.

[67] *See* https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/retirement/missing-participants-guidance/best-practices-for-pension-plans.

5. Cybersecurity

During April of 2021, the DOL released three guidance[68] items relating to cybersecurity:

- Tips for Hiring a Service Provider: "to help business owners and fiduciaries meet their responsibilities under ERISA to prudently select and monitor such service providers…"

- Cybersecurity Program Best Practices: "for use by recordkeepers and other service providers responsible for plan-related IT systems and data, and for plan fiduciaries making prudent decisions on the service providers they should hire."

- Online Security Tips: "Offers plan participants and beneficiaries who check their retirement accounts online basic rules to reduce the risk of fraud and loss."

The DOL has confirmed that cybersecurity inquiries have become a routine part of investigations. During audits of plan sponsors and recordkeepers, the DOL has requested cybersecurity and information security program policies, procedures, and guidelines.

6. FAQs Clarifying Timing of Lifetime Income Illustration Disclosures

The SECURE Act includes a provision requiring defined contribution plan administrators to provide participants with lifetime income illustrations that show the participant's current account balance both as a single life annuity and a qualified joint and survivor annuity income stream. This requirement applies even if a plan does not provide for annuity forms of distribution. Plan administrators are required to provide these illustrations annually.

In 2020, the DOL issued an interim final rule[69] implementing this provision of the SECURE Act. The interim final rule provides that the illustrations can be included in the regular pension benefit statement required under ERISA section 105 or in a separate disclosure. The rule also provides administrators with assumptions that must be used in preparing the illustrations and model language that can be used to satisfy this requirement.

On July 26, 2021, the DOL issued FAQs[70] clarifying the timing of lifetime income illustration disclosures. The FAQs state that the first disclosure:

- For participant-directed plans, must be incorporated on any quarterly statement no later than the second quarter of 2022 (i.e., the quarter ending June 30, 2022).

- For non-participant directed plans, must be on the statement for the first plan year ending on or after September 19, 2021.

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[68] *See* https://www.dol.gov/newsroom/releases/ebsa/ebsa20210414.

[69] 85 Fed. Reg. 59,132 (Sept. 18, 2020).

[70] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/temporary-implementing-faqs-lifetime-income-interim-final-rule.pdf.

C. Other Retirement Plan Guidance

1. PATH Act Collective Investment Trust Issue

In March, Church Alliance representatives met with IRS and Treasury officials to discuss the need for additional guidance under the Protecting Americans from Tax Hikes Act of 2015 ("PATH Act"). The PATH Act, which was signed into law in 2015, included a provision permitting church plan assets to be invested in a group trust described in Revenue Ruling 2011-1 without adversely affecting the tax status of the group trust. To date, Revenue Ruling 2011-1 has not been updated, despite requests by the Church Alliance.

During the March meeting, Church Alliance representatives requested that Revenue Ruling 2011-1 be updated to reflect the change made by the PATH Act and provided examples of issues that church plans have encountered in attempting to invest in group trusts.

2. GAO Studies on 403(b) Plans and Church Plans

During 2021, the Government Accountability Office ("GAO") announced that, at the request of Rep. Bobby Scott (D-VA), Chair of the House Education and Labor Committee, it had begun two studies, one indirectly involving church 403(b) plans and the other directly focusing on church pension plans. It appears that the 403(b) plan study was prompted by media articles that alleged that unreasonably high administrative and investment management fees were being charged by recordkeepers and investment fund advisors providing services and investment funds to 403(b) plans maintained by public school systems in the K-12 grade space. The GAO prepared a questionnaire which it sent to a number of large 403(b) recordkeepers and investment funds advisors and solicited input on a number of issues related to retirement plan fees. (At least one large denominational benefit board received the GAO questionnaire.) One of the questions in the questionnaire asked the recipients if they provided services to church 403(b) plans These plans were not otherwise implicated in the study.

The second GAO study appears to have been undertaken at the request of organizations that have supported litigation challenging the church plan status of church-affiliated hospital defined benefit plans. The focus of the second GAO study is not, however, limited to this narrow category of church plans—rather, it also will involve church plans sponsored by all types of eligible church plan sponsors, including churches and denominational benefit boards.

Representatives of the Church Alliance, along with representatives of a number of denominational benefit boards which are Church Alliance members, were interviewed by the GAO in connection with its study. Several church plan attorneys were also interviewed. However, the GAO interviews also included organizations and individuals which and who have expressed concerns about the ERISA church plan exemption in the past. It is impossible at this point to predict what the GAO will conclude in its church pension plan study as well as what recommendations it might make to Congress for changes in the law applicable to such plans. The Church Alliance will be closely monitoring the study and will keep Church Alliance members informed of issues related to it. The study is not expected to be completed until sometime in mid to late 2022.

3. Request for GAO Study on Health Care Sharing Ministries

On October 14, 2021, Rep. Bobby Scott (D-VA), Chair of the House Education and Labor Committee, and Rep. Mark DeSaulnier (D-CA), Chair of the House Health, Employment, Labor, and Pensions Subcommittee, sent a letter[71] to the GAO's U. S. Comptroller General requesting that the GAO assess the impact of health care offerings by health care sharing ministries and other arrangements that are exempt from certain requirements under state and federal law. The letter states that federal policymakers need a better understanding of these arrangements, including whether they could pose a risk to those who purchase them since they are exempt from the ACA and whether they could create the risk of adverse selection, potentially causing instability in premiums and higher costs for consumers of plans subject to federal and state regulation.

VII. REGULATORY AND OTHER INITIATIVES IMPACTING HEALTH AND WELFARE PLANS

A. Internal Revenue Service

1. Proposed Regulations on ACA Health Coverage Reporting

Shortly before this report was finalized, the IRS issued proposed regulations[72] providing guidance on the ACA information reporting of health coverage requirements under Code sections 6055 and 6056. Code section 6055 requires providers of minimum essential coverage to file and furnish statements about such coverage while Code section 6056 requires applicable large employers to file and furnish statements about the health insurance offered to full-time employees. The reporting is required to be made using Form 1095-B or 1095-C, as applicable, and must be filed with the IRS and furnished to individuals by certain deadlines. The deadline to furnish statements to individuals is currently January 31 of the year following the calendar year to which the statement relates although the IRS has issued notices extending this deadline for the past several years.

The proposed regulations would provide a permanent 30-day extension of time for both providers of minimum essential coverage and applicable large employers to furnish the required statements about health insurance coverage to individuals.[73] The proposed regulations also provide an alternative method for reporting entities to furnish individual statements as long as the individual mandate penalty remains zero.

Under the alternative method, a reporting entity must provide a clear and conspicuous notice on its website that contains certain information and states that individuals may receive a copy of their statement upon request. If an individual requests a statement, then the reporting entity must distribute the statement to the individual within 30 days of the date the request was received. With respect to applicable large employers that offer self-insured coverage to their

[71] *See* https://edlabor.house.gov/imo/media/doc/Scott%20&%20DeSaulnier%20GAO%20Request%20re%20Non-Compliant%20Plans2.pdf.

[72] *See* https://www.irs.gov/pub/irs-drop/reg-109128-21.pdf.

[73] The proposed regulations would not extend the deadline to file the forms with the IRS.

employees, the relief does not apply to statements for full-time employees but would apply to statements for employees who are not full-time or individuals who are not employees (e.g., COBRA participants). The reason the relief does not apply to the distribution of statements to full-time employees is because the required reporting form (i.e., Form 1095-C) includes certain information relating to the employer mandate.

2. Health Savings Account Limits

The IRS has announced the maximum contribution levels for HSAs and out-of-pocket spending limits for HDHPs that must be used in conjunction with HSAs for 2022.[74] The relevant amounts for 2022 are as follows:

Annual HSA contribution limit	**$3,650 –** individual coverage *($50 increase)* **$7,300 –** family coverage *($100 increase)*
Catch-up contribution limit over age 55	**$1,000** *(no change)*
Maximum HDHP out-of-pocket limit	**$7,050 –** individual coverage (*$50 increase*) **$14,100 –** family coverage (*$100 increase*)
HDHP minimum deductible	**$1,400 –** individual coverage (*no change*) **$2,800 –** family coverage (*no change*)

3. Flexible Spending Account, Qualified Transportation Fringe Benefit Limits, PCORI Fee, and Employer Mandate Affordability Percentage

The IRS has announced several inflation-adjusted items for 2022 under various provisions of the Code.[75] The relevant amounts for 2022 are as follows:

Annual contribution limit for Health Care FSA	**$2,850** *($100 increase)*
Maximum cafeteria plan carryover amount (if permitted)	**$570** (*$20 increase*)
Annual contribution limit for Dependent Care FSA	**$5,000**[76] *(unchanged)*
Qualified Small Employer HRA ("QSEHRA") Payment and Reimbursement Limit	**$5,450 –** individual coverage (*$150 increase*) **$11,050 –** family coverage (*$350 increase*)

[74] Rev. Proc. 2021-25.

[75] Rev. Procs. 2021-45 and 2021-36.

[76] The maximum tax-exempt benefits for dependent care assistance is $5,000 (this number is not indexed for inflation). The maximum for a dependent care flexible spending account is $2,500 (rather than $5,000) for married taxpayers filing separately. For the 2021 calendar year only, ARPA increased the dependent care FSA maximum to $10,500 (or $5,250 for married participants filing separately).

Monthly contribution fringe benefit exclusion limit for Qualified Mass Transportation and Qualified Parking under Code sections 132(f)(2)(A) and (B)	**$280** *($10 increase)*
Employer Mandate Affordability Percentage[77]	**9.61%** *(0.22% decrease)*

The IRS also announced the applicable dollar amount that is used in calculating the Patient Centered Outcome Research Institute ("PCORI") fee. In Notice 2020-84, the IRS provided that the adjusted applicable dollar amount used for purposes of calculating the PCORI fee for plan or policy years ending on or after October 1, 2020, and before October 1, 2021, is $2.66 (a $0.12 increase from the previous year).

B. Department of Health and Human Services

1. Prohibition on Sex Discrimination Includes Discrimination based on Sexual Orientation and Gender Identity

Section 1557 of the ACA prohibits discrimination under any health program or activity that received Federal financial assistance on any grounds prohibited by Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination and Employment Act of 1975, and section 504 of the Rehabilitation Act of 1973. The prohibited grounds for discrimination under these laws include race, color, national origin, age, disability, and sex.

In 2016, the DOL issued final regulations implementing Section 1557.[78] Later that year, plaintiffs filed a lawsuit against HHS, arguing that it exceeded its authority in interpreting sex discrimination as including gender identity and termination of pregnancy. The district court agreed and enjoined[79] and later vacated[80] the portion of the regulations relating to gender identity and termination of pregnancy.

In June 2020, HHS issued final regulations[81] substantially narrowing portions of the 2016 regulations, including the removal of the prohibition on discrimination based on gender identity and sex stereotyping. The final regulations include an exemption for self-insured health plans unless such plans receive Federal financial assistance or are principally engaged in the business of providing health care. Importantly, the final regulations include the clarification requested by the Church Alliance that the exemption for self-insured health plans applies to employer-

[77] The affordability percentage is the percentage used to determine whether employer-sponsored health coverage is affordable for purposes of the employer shared responsibility (or employer mandate) provisions. The adjusted affordability percentage of 9.61% applies to plan years beginning in 2022. Rev. Proc. 2021-36.

[78] 81 Fed. Reg. 31,376 (May 18, 2016).

[79] *Franciscan Alliance, Inc. v. Burwell*, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

[80] *Franciscan Alliance, Inc. v. Azar*, 414 F.Supp.3d 928 (N.D. Tex. 2019).

[81] 85 Fed. Reg. 37,160 (June 19, 2020).

sponsored plans not covered by ERISA, such as self-insured church plans, and to excepted benefits.

Prior to the effective date of the final regulations, the U.S. Supreme Court ruled that sex discrimination under Title VII includes discrimination based on sexual orientation and gender identity.[82] In light of the U.S. Supreme Court ruling, HHS announced that it will interpret and enforce Section 1557 and Title IX's prohibitions on discrimination based on sex to include discrimination on the basis of sexual orientation and gender identity.[83] In addition, the EEOC interprets Title VII to prohibit sexual orientation and gender identity discrimination when it comes to any aspect of employment, including hiring, firing, pay, job assignments, promotions, layoff, training, fringe benefits, and any other term or condition of employment.[84]

2. Health Plan Cost-Sharing Limits

HHS has announced the maximum annual limits on cost-sharing that apply to non-grandfathered plans for 2022.[85] The relevant amounts for 2022 are as follows:

Self-Only Coverage	**$8,700** *($150 increase)*
Other than Self-Only Coverage	**$17,400** *($300 increase)*

The limits are $400 less than the proposed limits because the final limits reflect a changed methodology for 2022.

C. Department of Labor

1. Claims Procedures

On June 14, 2021, the Employee Benefits Security Administration ("EBSA") issued an Information Letter[86] considering whether call center claim-related audio recordings and transcripts must be provided, upon request, to a claimant (or authorized representative) under claims procedure rules. EBSA ruled that the transcript must be provided even if: (i) the recording or transcript is not included in the administrative record, (ii) the plan or claims administrator does not treat the recording or transcript as part of the claim history through which it develops, tracks, and administers the claim; or (iii) the recording or transcript was only made for quality assurance purposes.

[82] *Bostock v. Clayton Cnty., Ga.*, 140 S. Ct. 1731 (2020).

[83] *See* 86 Fed. Reg. 27,984 (May 25, 2021) and https://www.hhs.gov/about/news/2021/05/10/hhs-announces-prohibition-sex-discrimination-includes-discrimination-basis-sexual-orientation-gender-identity.html.

[84] *See* https://www.eeoc.gov/sex-based-discrimination.

[85] 86 Fed. Reg. 24,140 (May 5, 2021)

[86] *See* https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/information-letters/06-14-2021.

D. Internal Revenue Service, Department of Labor, and Health and Human Services Joint Guidance

1. Final Grandfathered Health Plan Regulations

On December 11, 2020, the Agencies issued final regulations[87] that would amend the current grandfathered plan rules as follows:

- The final regulations provide another option for measuring the maximum permitted increase in cost-sharing for grandfathered plans. The new option would determine permitted increases by reference to the most recently published "premium adjustment percentage," which is published annually by HHS and better accounts for changes in the cost of health coverage over time.

- HDHPs that must increase cost-sharing amounts to remain an HDHP would not lose grandfathered status.

The final regulations are substantially the same as the proposed regulations issued during the summer of 2020. The final regulations became effective on June 15, 2021.

2. FAQ Guidance on Preventive Services

Coverage of HIV-Related Medication

All non-grandfathered plans must provide coverage for certain preventive care services without the imposition of any cost-sharing requirements (such as a copayment, coinsurance or deductible), including certain evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). As a result of a recommendation of the USPSTF, non-grandfathered health plans are required to cover without cost sharing pre-exposure prophylaxis ("PrEP") effective for plan years beginning on or after June 30, 2020. PrEP is an antiretroviral therapy for persons who are at high risk of acquiring human immunodeficiency virus ("HIV").

The Agencies issued FAQ guidance[88] on July 19, 2021, to clarify that the requirement to cover PrEP applies to all items and services that the USPSTF recommends should be received by a participant prior to being prescribed PrEP and for ongoing follow-up and monitoring. These services include HIV testing, hepatitis B and C testing, pregnancy testing, sexually transmitted infection screening and counseling, and adherence counseling along with certain other services specified in the FAQs. The FAQs also clarify that the plan must cover without cost-sharing the office visit associated with these services when the service is not billed separately from the office visit and the primary purpose of the visit was the delivery of the preventive service.

Further, the FAQs clarify that a plan may not use reasonable medical management techniques to restrict the frequency of PrEP services, to the extent the frequency is specified in

[87] 85 Fed. Reg. 81,097 (Dec. 15, 2020).

[88] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-47.pdf.

the USPSTF recommendation. In contrast, a plan may use reasonable medical management techniques to encourage individuals prescribed PrEP to use specific items or services to the extent the frequency, method, treatment, or setting is not specified in the USPSTF recommendation, such as covering the generic version without cost sharing and the name brand version with cost sharing, subject to the exceptions process set forth in the FAQs.

Because plans may not have fully understood the requirement to cover all the support services for PrEP, the Agencies agreed that they will not take enforcement action against a plan for failing to provide coverage of these services through September 17, 2021.

Contraceptive Coverage

The ACA requires non-grandfathered health plans to cover certain preventive care services without cost-sharing, including contraceptive coverage. In 2018, the Agencies issued final regulations expanding the exemptions from the requirement to provide contraceptive coverage without cost-sharing for organizations with moral or religious objections. In August, the Agencies issued an FAQ[89] stating that they intend to issue regulations by February of 2022 to amend the 2018 regulations considering recent litigation.

E. Equal Employment Opportunity Commission

1. Proposed Wellness Plan Rules

The EEOC issued proposed wellness rules under both the ADA and GINA on January 7, 2021. As a result of the Biden administration's regulatory freeze on certain unpublished regulations, the EEOC withdrew the proposed rules on February 12, 2021, and removed them from their website.[90] The website now states that "next steps" are "under consideration."

Prior to withdrawal, the proposed rules provided guidance on the types of wellness programs that are considered "voluntary" under the ADA and GINA. The withdrawn rules would have permitted an employer to offer "de minimus" incentives under a participatory wellness program that involves the disclosure of health information, such as a water bottle or a modest gift card. In addition, the withdrawn rules would have permitted health-contingent voluntary wellness programs offered in connection with a group health plan to offer incentives to the extent consistent with HIPAA rules (i.e., up to 30% of the cost of coverage and 50% for tobacco cessation).

F. Other Health and Welfare Plan Guidance

1. Congress Request for Information on Public Health Option

On May 26, 2021, the House Committee on Energy and Commerce and the Senate Committee on Health, Education, Labor & Pensions issued a request for information[91] on design

[89] *See* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-48.pdf.

[90] Before being withdrawn, a coalition of business groups asked the EEOC to issue guidance regarding the extent employers could offer employees incentives to receive COVID-19 vaccination without violating the ADA.

[91] *See* https://www.americanbenefitscouncil.org/pub/?id=0A0779A9-1866-DAAC-99FB-0142F58467F6.

considerations for a public health option, including how it can lower the cost of health care and expand coverage. According to the request for information, "Our goal in establishing a federally administered public option is to work towards achieving universal coverage, while making health care simpler and more affordable for patients and families."

The Church Alliance responded to the request for information on July 30, 2021. The Church Alliance's response pointed out several special considerations about church health care plans and requested that those considerations be considered in drafting the legislation.[92]

2. Senate Finance Committee Request for Information on Behavioral Health Care Needs

On September 21, 2021, Senators Ron Wyden, Chairman of the Committee on Finance, and Mike Crappo, Ranking Member of the Committee on Finance, issued a request for information[93] on legislation that would improve access to health care for Americans with mental health and substance use disorders. In particular, the request seeks "evidence-based solutions and ideas to enhance behavioral health care in the following areas: a) strengthening the workforce; b) increasing integration, coordination, and access to care; c) ensuring parity between behavioral and physical health care; d) furthering the use of telehealth; and e) improving access to behavioral health care for children and young people."

The Church Alliance submitted a comment letter on November 1, 2021, supporting the efforts to strengthen the behavioral health workforce. The comment letter also suggests expanding telemedicine and adopting laws that would make the current COVID-19 waiver of certain telemedicine state-based restrictions permanent.

3. Blue Cross Blue Shield Class Action Settlement

Litigation has been ongoing for around ten years involving whether the structure of the Blue Cross Blue Shield organizations and the way in which this structure limits competition among these organizations violates the U.S. antitrust laws. The parties involved in the case—individuals and insured and self-insured plans purchasing health care coverage from Blue Cross Blue Shield organizations on the plaintiffs' side, and the national Blue Cross Blue Shield association and the individual Blue Cross Blue Shield organizations on the defendants' side, reached a settlement of this class action lawsuit in April of 2021.

After representatives of a number of church benefit boards sponsoring church self-insured health care plans examined the proposed settlement, it became clear that their plans had been left out of a settlement class that would, among other things, permit a church self-insured plan to secure a bid on the provision of health care plan administration from more than one Blue Cross Blue Shield organization. Once this discovery was made, and after extensive discussion with plaintiffs' counsel who represent a number of employers and plans that have decided to opt

[92] *See* https://church-alliance.org/comment-letters/church-alliance-files-response-request-information-public-health-insurance-option.

[93] *See* https://www.finance.senate.gov/imo/media/doc/092221%20Bipart%20mental%20health%20RFI.pdf.

out of the settlement agreement, the church benefit boards involved in this discussion decided to do the same.

At this juncture, it appears that the judge hearing the case will enter an order approving or disapproving the settlement agreement in January or February of 2022. It also appears at this point that the judge will permit the objecting church self-insured health care plans to opt out of the settlement and pursue their own antitrust claims against the Blue Cross Blue Shield organizations, in particular their claim that they also should be entitled to a "second bid" right from other Blue Cross Blue Shield organizations. However, the exact scope of relief to be granted to church plans by the trial judge will not be clear until his order approving or disapproving the settlement is entered.

VIII. LITIGATION

A. U.S. Supreme Court Ruling on Individual Mandate

In February of 2018, a lawsuit was filed challenging the constitutionality of the individual mandate. Because the U.S. Supreme Court upheld the individual mandate in 2012 as a legitimate use of Congress' taxing power, the plaintiffs argued that the reduction of the individual mandate penalty to zero under the Tax Cuts and Jobs Act makes it unconstitutional. The plaintiffs also argued that the individual mandate cannot be severed from the rest of the ACA and, therefore, the entire law is unconstitutional.

Democratic state attorneys general from several states and the District of Columbia intervened in the case to defend the ACA. They argued that the individual mandate is still constitutional and, even if the court determined it is unconstitutional, it could be severed from the rest of the ACA.

In December 2018, a district court declared the individual mandate unconstitutional.[94] The court also declared the entire ACA invalid after determining that the remaining provisions are inseverable from the individual mandate.

On appeal, the Fifth Circuit Court of Appeals decided the individual mandate is unconstitutional but remanded the case to the district court to determine which parts of the ACA are severable from the individual mandate.[95]

A coalition of Democratic attorneys general and the U.S. House of Representatives appealed the Fifth Circuit's decision to the U.S. Supreme Court. On June 17, 2021, the U.S. Supreme Court dismissed the case, stating that the plaintiffs did not have standing to sue because they could not show an injury resulting from its enforcement.[96]

[94] *Texas v. U.S.*, 340 F.Supp.3d 579 (N.D. Tex. 2018).

[95] *Texas v. U.S.*, 945 F.3d 355 (5th Cir. 2019).

[96] *California v. Texas*, 141 S. Ct. 2104 (2021).

B. Church Plan Litigation Update

Numerous lawsuits have been filed in the last several years challenging the availability of the ERISA church plan exemption to defined benefit plans sponsored by several different religiously affiliated health care systems. A settlement was reached in one recent case.

In *Rollins v. Dignity Health*, the plaintiffs claimed that Dignity Health improperly used the church plan exemption in ERISA to evade ERISA's funding and reporting requirements for its defined benefit plan. Under the settlement agreement,[97] Dignity Health will make substantial contributions to the plan over the next several years (contributions which Dignity Health was already making). Dignity Health will also make two separate one-time payments to certain classes of participants. In addition, Dignity Health agreed to make a summary plan description, summary annual report, and pension benefit statements available to plan participants.

The Church Alliance continues to monitor the progress of church plan status cases.

C. Mental Health Parity Litigation Settlement

In *Walsh v. United Behavioral Health*, the DOL sued United Behavioral Health and other related parties ("United") under ERISA over possible violations of the Mental Health Parity Act. The Mental Health Parity Act generally prohibits plans from imposing limitations on mental health and substance use disorder benefits that are more restrictive than the limitations imposed on medical and surgical benefits. The treatment limitations at issue in the case were NQTLs, which are limitations on the scope or duration of benefits for treatment that are not expressed by number.

Specifically, the DOL's complaint alleged that:

- United set policies and adjudicated claims in a manner that caused health plans to reimburse participants for out-of-network mental health services in a more restrictive manner than they reimbursed participants for out-of-network medical and surgical services.

- United imposed a concurrent review program (which is sometimes also referred to as outlier management) to limit mental health and substance use disorder benefits to a greater extent than the programs in place for medical and surgical benefits.

- United's disclosures to plans and participants did not include sufficient details on the reimbursement rate or the concurrent review program.

Each year, the DOL engages in numerous mental health parity investigations.[98] If a plan is found to be out of compliance, then the DOL has generally required corrective action. This is the first time the DOL has brought litigation under ERISA to enforce the Mental Health Parity

[97] *See* https://www.plansponsor.com/parties-church-plan-lawsuit-finally-get-preliminary-approval-settlement/?utm_source=newsletter&utm_medium=email&utm_campaign=Newsdash.

[98] *See* https://www.jdsupra.com/legalnews/u-s-department-of-labor-settles-9787697/.

Act against a health insurance issuer, health plan, or administrative service provider. The DOL brought this case under ERISA section 502(a)(5) to seek injunctive relief and penalties for violations of the Mental Health Parity Act by a fiduciary of the plans. The litigation may show the increased emphasis the current administration is placing on mental health parity enforcement and that the DOL has decided to focus on enforcement actions against service providers instead of employer plan sponsors.

In August, the case settled for more than $15.6 million dollars, to be split between the DOL, the New York Attorney General, and plan participants.

D. Fee Litigation

New cases continue to be filed alleging that retirement plan sponsors and committees are breaching their ERISA fiduciary duties to retirement plans and plan participants by paying excessive and unreasonable fees to retirement plan recordkeepers, administrative service providers, and investment providers. These cases have been filed against large, for-profit companies sponsoring 401(k) plans, and college and university 403(b) plans.

In *Sweda v. University of Pennsylvania*, the defendant's employees challenged the fees and investment options in the university's 401(k) plan. This lawsuit was settled on December 2, 2020, for $13 million.[99] The defendant also agreed to begin using a single recordkeeper for the plan, include lower cost investment options, and direct the plan's recordkeeper to stop using participant information to market unrelated financial products to them.

The U.S. Supreme Court will also consider fee litigation involving two 403(b) plans sponsored by Northwestern University. In a Petition for a Writ of Certiorari, the plaintiffs argue that the appeal court's dismissal of their complaint conflicts with other federal appeals decisions involving similar issues, thereby creating a circuit split.[100] On July 2, 2021, the U.S. Supreme Court announced that it will hear the case, and oral arguments have been set for December 6, 2021.[101]

E. U.S. Supreme Court Ruling in Pharmacy Benefit Manager Preemption Litigation

In *Rutledge v. Pharmaceutical Care Management Association*,[102] the Court of Appeals for the Eighth Circuit held that ERISA preempts an Arkansas state law that regulates maximum allowance cost ("MAC") lists created by PBMs. MAC lists generally establish reimbursement rates at which PBMs will reimburse pharmacies dispensing generic drugs. The PBM in the case argued that the Arkansas law regulates plan administration and is, therefore, preempted by ERISA. The State of Arkansas argued that the law simply regulates the PBM reimbursement rates and is, therefore, protected from ERISA preemption.

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[99] *See* https://www.pionline.com/courts/university-pennsylvania-pay-13-million-settle-erisa-case.

[100] Divane v. Northwestern Univ., 953 F. 3d 980 (7th Cir. 2020), petition for cert. filed, Hughes v. Northwestern Univ. (U.S. June 19, 2020).

[101] Id., cert. granted, Hughes et al. v. Northwestern University et al. (U.S. July 2, 2021) (No. 19-1401).

[102] *Rutledge v. Pharm. Care Mgmt. Ass'n*, 891 F. 3d 1109 (8th Cir. 2018).

Arkansas submitted a petition for a writ of certiorari with the U.S. Supreme Court, which was granted.[103] On December 10, 2020, the U.S. Supreme Court held that ERISA did not preempt Arkansas's law regulating PBMs.[104]

IX. OTHER

A. Final Regulations on Excise Tax Imposed on Excess Executive Compensation Paid by Certain Tax-Exempt Organizations

The Tax Cuts and Jobs Act added Section 4960 to the Code, imposing an employer-paid 21% excise tax on excess executive compensation paid by tax-exempt organizations. On January 19, 2021, the IRS issued final regulations[105] under Code Section 4960, which are substantally the same as the proposed regulations issued in 2020.

Under Code section 4960, excess executive compensation includes:

- Any *remuneration* paid (other than an excess parachute payment) by an applicable tax-exempt organization for a taxable year with respect to employment of any *covered employee* in excess of $1 million, plus

- Any excess *parachute payment* paid by such organization to any covered employee.

A "covered employee" is any employee (or former employee) of an applicable tax-exempt organization if the employee is one of the five highest compensated employees of the organization for the taxable year or was a covered employee of the organization (or a predecessor) for any preceding taxable year beginning after December 31, 2016. The covered employee list must be monitored and will grow over time.

"Remuneration" means wages as defined for income tax withholding purposes and any amount required to be included in gross income under Code Section 457(f) but excludes any designated Roth contributions. Remuneration that is a regular wage is treated as paid on the date it is actually or constructively received, and all other renumeration is treated as paid when there is no substantial risk of forfeiture of the rights to such remuneration, even if it has not yet been actually received by the covered employee. It is important to note that wages for withholding purposes do not include compensation received in the exercise of ministry by an ordained, licensed or commissioned pastor, and such compensation, therefore, will not be treated as remuneration under Code Section 4960.

For purposes of determining whether an employee is one of the five highest-compensated employees for a year, remuneration paid by the organization and certain related organizations is aggregated. Some commenters expressed concern that the excise tax would apply to situations in which an employee of one organization performs limited, temporary, or volunteer services for a

[103] *Id., cert. granted*, 140 S. Ct. 812 (U.S. Jan. 10, 2020) (No. 18-540).

[104] *Id.*, 141 S. Ct. 474 (2020).

[105] 86 Fed. Reg. 6,196 (Jan. 19, 2021).

related applicable tax-exempt organizations. The regulations include rules to address these concerns.

A "parachute payment" is a payment in the nature of compensation to (or for the benefit of) a covered employee if the payment is made as a result of the employee's involuntary separation from employment, and the aggregate present value of all such payments equals or exceeds three times the base amount.[106] The excise tax applies as a result of an excess parachute payment, even if the covered employee's remuneration is less than $1 million. Parachute payments do not include payments under a qualified retirement plan, a simplified employee pension plan, a simple retirement account, a Section 403(b) tax-deferred annuity, or a plan described in Code Section 457(b). Parachute payments include nonqualified deferred compensation payments. Accordingly, the 21% excise tax could be triggered if an executive (covered employee) participates in a nonqualified deferred compensation plan, is involuntarily terminated, and as a result receives a large payment from a nonqualified plan.

Payments from 457(b) plans do not count as excess parachute payments, but are treated as wages and therefore constitute remuneration for Code section 4960 purposes. Payments from 457(f) plans also constitute remuneration.

The final regulations are effective for taxable years beginning after December 31, 2021. Prior to the effective date, taxpayers may choose to rely on the guidance in Notice 2019-09, the proposed regulations, or the final regulations, provided they apply the chosen rules in their entirety.

B. EEOC Update to Compliance Manual On Religious Discrimination

On January 15, 2021, the EEOC issued the final update to the religious discrimination section of its Compliance Manual,[107] which was last updated in 2008. The updated section reflects recent case law under Title VII of the Civil Rights Act relating to religious discrimination and the legal protections available to certain religious employers, including the ministerial exception.

C. Church Alliance Comment Letter to SEC on Climate Change Disclosures

In March, the Securities and Exchange Commission ("SEC") requested public comments on climate change disclosure rules and guidance. The Church Alliance filed a comment letter[108] in June commending the SEC for recognizing investors' needs for these types of disclosures and soliciting public comment. The Church Alliance also encouraged the SEC to design a disclosure framework that is broader than just climate change-related risks and opportunities and includes other ESG factors.

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[106] "Base amount" is defined as the average annualized compensation includible in the covered employee's gross income for the five taxable years ending before the date of the employee's separation from employment.

[107] *See* https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination.

[108] *See* https://church-alliance.org/comment-letters/response-sec-request-public-input-regarding-climate-change-disclosure-rules-and.

D. Issues Being Monitored by the Church Alliance

1. 2021-2022 Priority Guidance Plan

On September 9, 2021, the Department of Treasury and the IRS released its 2021-2022 Priority Guidance Plan ("PGP"). A list of the items the Church Alliance has flagged to generally monitor in the 2021-2022 iteration of the PGP is below. Additionally, the Church Alliance continues to watch for the church plan definition rulemaking release, though that project has not been included in the last two iterations of the PGP.

Employee Benefits – Retirement Benefits

- Guidance relating to certain IRS, Tax Exempt and Government Entities, Employee Plans programs, including the Pre-approved Plan Program, the Determination Letter Program, and the Employee Plans Compliance Resolution System (EPCRS) (which was published in Revenue Procedure 2021-30 and is further discussed in Section VI.A.2).

- Regulations updating electronic delivery rules and other guidance for providing applicable notices and making participant elections.

- Guidance on student loan payments and qualified retirement plans and §403(b) plans.

- Regulations and related guidance on the exception to the unified plan rule for §413(e) multiple employer plans. Proposed regulations under §413(c) were published on July 3, 2019.

Exec Comp, Health Care/Other Benefits, and Employment Taxes

- Regulations under §457(f) and related guidance on ineligible plans. Proposed regulations were published on June 22, 2016.

- Guidance on contributions to and benefits from paid family and medical leave programs.

- Final regulations under §§4980H and 105(h) related to HRAs. Proposed regulations were published on September 30, 2019.

Exempt Organizations

- Guidance revising Rev. Proc. 80-27 regarding group exemption letters. Notice 2020-36 was published on May 18, 2020.

- Guidance on circumstances under which an LLC can qualify for recognition under §501(c)(3).

- Final regulations on §509(a)(3) supporting organizations. Proposed regulations were published on February 19, 2016.

- Regulations under §512 regarding the allocation of expenses in computing unrelated business taxable income and addressing how changes made to §172 net operating losses by section 2303(b) of the CARES Act apply for purposes of §512(a)(6).

2. State Law Initiatives

The Church Alliance continues to monitor state legislative proposals that could potentially impact church plans. On health care, the Church Alliance has been monitoring proposals relating to surprise billing and transparency requirements, the ACA, PBMs and drug pricing, and health benefits. With respect to health benefits, the Church Alliance has been particularly interested in monitoring proposals that would mandate new benefits or disclosure of benefit information. On retirement, the Church Alliance has been monitoring proposals that would establish state multiple employer plans or automatic enrollment IRA plans. Finally, the Church Alliance has been monitoring state privacy proposals, which would allow consumers to request certain categories of personal information and/or restrict disclosure of personal information.

E. Social Security Cost of Living Adjustments

On October 13, 2021, the Social Security Administration announced the cost-of-living adjustments for 2022.[109] The cost-of-living adjustments for 2022 are as follows:

Increase in monthly benefits	5.9%
Maximum earnings subject to Social Security taxes	$147,000 (*$4,200 increase*)
Maximum earnings subject to Medicare taxes	Unlimited
Exempted earnings amount:[110] • In year prior to year during which retiree reaches full retirement age • In year during which retiree reaches full retirement age	 $19,560 *($600 increase)* $51,960 *($1,440 increase)*

[109] Social Security Press Release, October 13, 2021, https://www.ssa.gov/news/press/releases/2021/#10-2021-2.

[110] The "exempted earnings amount" is the amount of annual earnings a retiree who is under full retirement age can earn without a reduction in Social Security benefits. There is no reduction for a retiree who has attained full retirement age.