Verrill

Benefits Law Update

Employee Benefits & Executive Compensation Group

Client Advisory
Summer 2021

This Client Advisory summarizes developments in the law governing employee benefit plans prompted by the COVID-19 pandemic. We explain what these developments mean for plan sponsors and highlight the need to adopt plan amendments within limited time periods in order to fully implement pandemic-related changes. As plan amendment deadlines approach, plan sponsors should inventory changes made to their employee benefit plans in response to pandemic-related changes in law. We also highlight a few key non-pandemic-related developments and upcoming plan amendment and administrative deadlines.

The following topics are covered (click on a topic to go directly to the summary):

Welfare Benefit COVID-19 Relief – Reminder to Amend Plan Documents

The federal government provided a range of special COVID-19 relief that affects the operation of health and welfare benefit plans. Specifically, IRS Notice 2020-29 and Section 214 of the Consolidated Appropriations Act of 2021 (**CAA**) provide a substantial amount of flexibility for the operation of health and dependent care Flexible Spending Accounts (**FSAs**). In addition, joint agency guidance delayed several procedural deadlines that apply to ERISA benefit plans, the Coronavirus Aid, Relief, and Economic Security (**CARES**) Act expanded the definition of "qualified health expenses," IRS Notice 2020-33 increased the carryover limit for health FSAs, and the American Rescue Plan Act of 2021 (**ARPA**) increased the maximum benefit limit on dependent care expenses.

Of primary importance for plan sponsors now is the requirement to amend plan documents to memorialize the relief provided during the 2020 plan year. Amendments to incorporate the additional flexibility provided under IRS Notice 2020-29 and the CAA must be adopted by the last day of the first calendar year beginning after the end of the plan year in which the relief is effective. This means that for calendar year plans, **for changes first effective in 2020 an amendment must be adopted no later than December 31, 2021**, and **for changes first effective**

in 2021 an amendment must be adopted no later than December 31, 2022. Plan sponsors should work with their ERISA counsel and their third-party administrator or other document vendor to ensure that plan documents are timely amended to include any optional relief.

We have created a table that provides an overview of the COVID-19 relief available for health and welfare benefit plans. (Click here to access the table.) If a plan sponsor implemented any of the optional provisions described in the table, a plan amendment is required.

Notice of Expiration of ARPA COBRA Premium Subsidy

All plan sponsors should already be aware that certain individuals may be eligible for COBRA premium assistance under the American Rescue Plan Act of 2021 (**ARPA**). An assistance-eligible individual is one who has lost group health insurance coverage due to a reduction in hours or involuntary termination, has elected COBRA continuation coverage, and is not eligible for coverage under another group health plan or Medicare.

ARPA requires plan sponsors to notify assistance-eligible individuals of their eligibility for premium assistance and when their eligibility will expire. Plan sponsors can be penalized for failing to provide the notice of expiration of the period of premium assistance, currently scheduled for September 30, 2021. An assistance eligible individual should be notified 15 to 45 days before their premium assistance expires. Accordingly, **a notice of expiration of the period of premium assistance must be provided to most assistance-eligible individuals who made a COBRA election no later than September 15, 2021, and not before August 16, 2021**.

The Department of Labor (**DOL**) has provided a model notice that can be customized to meet a plan sponsor's needs. Use of the DOL model notice will be considered good faith compliance with ARPA content and notice requirements. The DOL model notice of expiration of the period of premium assistance is available here. Failure to satisfy the ARPA requirements – including failing to meet notice requirements – may subject a plan sponsor to an excise tax of as much as $100 per assistance-eligible individual (a maximum of $200 per family) for each day that the plan sponsor is in violation of a requirement.

Employer Vaccine Mandates and Incentive Programs

U.S. Equal Employment Opportunity Commission (**EEOC**) guidance permits employers looking to increase the rate of COVID-19 vaccination of their workforce to provide incentives for employees to get vaccinated or to mandate that employees get vaccinated. The guidance (available here) clarifies the legal requirements for incentive programs and outlines an employer's ability to mandate COVID-19 vaccinations.

The EEOC guidance confirms that employers may offer incentives to employees to provide proof of vaccination. Vaccination incentives can take the form of either a reward or penalty but must not be so substantial as to be coercive. An employer may not provide incentives for an employee's family members to be vaccinated by the employer or its agent, because the Genetic

Information Nondiscrimination Act of 2008 (**GINA**) prohibits an employer from asking the employee's family members pre-vaccination medical screening questions, responses to which include genetic information about the employee.

The guidance does not explain what the EEOC views as an incentive level that would be "coercive," or whether HIPAA wellness program rules might apply to a particular program. It does, however, provide a baseline for employers to design their vaccination incentive programs. For more information about vaccination incentive programs, see our blog post here.

The EEOC guidance also confirms that an employer is permitted to require all employees physically entering the workplace to be vaccinated for COVID-19, so long as the employer provides a reasonable accommodation for employees who cannot receive the vaccine. The guidance does not address whether state law or federal laws other than the Americans with Disabilities Act and GINA might affect vaccination mandates. The EEOC reminds employers that because some individuals or demographic groups may face greater barriers – health-related and otherwise – to receiving a COVID-19 vaccination, some employees may be more likely to be adversely affected by a vaccination requirement.

Massachusetts Now Requires Paid COVID-19 Leave for all Employees

Massachusetts now requires all employers, regardless of size, to offer their Massachusetts employees paid, job-protected leave for certain COVID-19-related reasons, including to get or recover from a COVID-19 vaccine. Massachusetts also has established a fund to reimburse employers for the cost of providing COVID-19 paid leave required by the law.

Effective May 28, 2021, the law requires employers to provide all employees up to 40 hours (pro-rated for part-time employees) of paid leave. Employers are required to provide leave until the earlier of September 30, 2021, or when Massachusetts announces that the $75 million fund to reimburse employers is expected to be depleted. The law applies to any employee whose primary place of employment is in Massachusetts, regardless of where the employer is located, and includes employees who live in Massachusetts and telecommute.

Employees are eligible to take leave for any of the following reasons:

- The employee or the employee's family member needs to self-isolate because of a COVID-19 diagnosis, or needs medical diagnosis, care, or treatment for COVID-19 symptoms.
- The employee requires leave to get or recover from a COVID-19 vaccination.
- A quarantine order or similar determination regarding the employee or the employee's family member by a local, state, or federal public official, a health authority having jurisdiction, or a health care provider.
- The employee is unable to telework due to COVID-19 symptoms.

In general, employers may not require employees to use other types of available paid leave before they use COVID-19 paid leave or require employees to search for or find a replacement worker to cover the time the employee will miss.

The maximum benefit employers are required to provide an employee for all leave taken under the law is $850. Employers are permitted to provide additional COVID-19 paid leave benefits to employees but will only be eligible for reimbursement for up to $850. For employees who earn less than $850 per week, employers will not be eligible for reimbursement of amounts in excess of the employee's typical weekly wages.

Employers are required to post a notice at their workplace describing COVID-19 paid leave. Massachusetts has provided a sample notice. For more information and specific advice for implementing a program to provide COVID-19 paid leave, see our blog post here.

Preparing for CARES Act Retirement Plan Amendments

Retirement plan sponsors should inventory temporary changes made to their plans during the pandemic under the Coronavirus Aid, Relief, and Economic Security (**CARES**) Act. Some of these temporary provisions will require plan amendments. Although plan sponsors generally have until the end of next year to amend their plans, there are steps a plan sponsor can take now, such as identifying and recording which changes were implemented and when, that will be helpful when it comes time to adopt the required plan amendments.

The CARES Act made available the following retirement plan enhancements:

- Created a new type of distribution from defined contribution plans. If elected by the plan sponsor, individuals affected by COVID-19 were permitted to take "coronavirus-related distributions" of up to $100,000 until December 31, 2020. These distributions are generally taxable over three years, or, to avoid taxation, recipients may repay coronavirus-related distributions within three years or roll over the distribution to another eligible retirement plan. A repayment to the plan is treated as a rollover contribution, so plans that do not permit rollover contributions must be amended if participants are permitted to repay coronavirus-related distributions. For more information about coronavirus-related distributions and subsequent IRS guidance, see our blog post here.

- Temporarily increased the maximum amount a participant affected by COVID-19 may borrow from qualified retirement plans and 403(b) plans to $100,000 for loans made during the 180-day period beginning on March 27, 2020, and ending on September 23, 2020. The Act also permitted retirement plans to allow participants affected by COVID-19 to delay payments on plan loans due between March 27, 2020, and December 31, 2020, for up to one year. Participants who delayed loan repayments were required to restart loan repayments as of January 1, 2021, with required payments adjusted to reflect the delay and any interest accruing during the delay. Following the delay, the total repayment period for the loan may be extended for up to one year.

  The IRS provided a safe harbor method of implementing these provisions. Under the safe harbor method in Notice 2020-50, interest that accrued during the suspension period

must be added to the outstanding loan balance. The loan is then reamortized on January 1, 2021, over the remaining term of the loan, including up to a one-year extension from the date the loan was originally due. Loan payments must be recalculated to be substantially equal over the remaining period of the loan. For more information about the CARES Act plan loan provisions and subsequent IRS guidance, see our blog post here.

- Waived required minimum distributions (**RMD**s) for 2020 from tax-qualified defined contribution plans, 403(b) plans, and governmental 457(b) plans. The waiver applies to (1) RMDs for 2020, including RMDs for which the required beginning date was April 1, 2021; and (2) RMDs for 2019 for which the required beginning date was April 1, 2020, and that were not paid in 2019. Plans will need to be amended to specify whether RMDs were suspended by default or participants were given an opportunity to elect to suspend RMDs. Additionally, the CARES Act and subsequent IRS guidance created opportunities for RMDs distributed in 2020 and RMDs for 2020 distributed in 2021 to be recontributed to the plan as rollover contributions or rolled over to another eligible retirement plan. If an employer's retirement plan did not previously accept rollover contributions, but participants were permitted to recontribute RMDs, the plan will need to be amended to reflect this change.

An employer that chose to offer any of these enhancements to employees – or any aspects of these enhancements – is required to amend its retirement plan by December 31, 2022 (or the last day of the first plan year beginning after January 1, 2022, for non-calendar year plans). Additionally, plan administrative documents, such as the plan's loan procedures, may need to be updated to reflect these changes.

Reminder: Plan Amendments to Hardship Distribution Rules Due by December 31

Sponsors of 401(k) plans and 403(b) plans should be aware that plan amendments to comply with the IRS's 2019 final regulations on hardship distributions are generally required by December 31, 2021.

The final regulations include several changes to the rules governing hardship distributions, including prohibiting the suspension of elective deferrals or employee contributions for a period of six months following receipt of a hardship distribution, and creating a single standard for determining whether a distribution is necessary to satisfy and immediate and heavy financial need. Plans that previously required a 6-month suspension of elective deferrals or employee contributions must be amended to eliminate the suspension. Additionally, the regulations provide several optional changes. If a plan sponsor chose to implement any of the optional changes, the plan must be amended to reflect the change.

For detailed information about the final regulations, see our blog post here.

A High-Level Overview of Health Care Transparency Requirements

The Consolidated Appropriations Act of 2021 (**CAA**) and the Transparency in Coverage final rule published on November 12, 2020, create myriad new requirements for group health plans, their sponsors, and plan service providers. Plan sponsors who are not already doing so should begin addressing compliance with the final rule and CAA provisions with their brokers, insurance carriers, and third-party administrators (**TPA**s) immediately. Though enforcement of certain requirements may be delayed, the CAA and final rule create significant new burdens for plans and will likely require revisions to plan service provider contracts.

Transparency in Coverage Final Rule

The Transparency in Coverage final rule is a companion rule to the hospital transparency final regulation, effective January 1, 2021, which requires hospitals to publish their standard charges for the goods and services they provide. The final rule applies to group and individual health insurance coverage, as well as self-insured group health plans subject to ERISA, and requires health insurance plans to provide two types of disclosures.

1. *Public disclosure tool* – The public disclosure portion of the final rule is effective January 1, 2022, and requires plans to create an online tool that makes three types of detailed cost-sharing information for the plan's health care providers available to the public:

    - The negotiated rate between the plan and in-network providers for all covered services,
    - The plan's payments to and billed charges from out-of-network providers, and
    - Negotiated rates and historical net prices for all covered prescription drugs (including the cost of drugs obtained through a pharmacy benefit manager (**PBM**)).

    Plans will be required to update the three data files on a monthly basis and provide the information in a readily accessible format.

2. *Cost estimate disclosure tool* – The final rule also requires plans to provide participants with a tool that will allow a participant to estimate medical costs prior to the participant's episode of care. This disclosure must include information regarding a particular member's cost-sharing obligations, similar to an explanation of benefits (**EOB**) form. The cost estimate tool requirement is intended to be phased in over time. Information concerning a list of 500 "shoppable services" such as tonsil removal, knee replacement, x-rays, and colonoscopies must be available for plan years beginning on or after January 1, 2023. Information regarding all remaining services must be available for plan years beginning on or after January 1, 2024.

Insurance carriers are responsible for compliance with the final rule as it applies to individual coverage and fully insured plans. Sponsors of self-insured plans, however, must assure compliance with the final rule and, thus, will rely heavily on their TPAs to implement the transparency requirements. Accordingly, sponsors of self-insured plans should begin discussing

amendments to their Administrative Services Agreements and PBM contracts to ensure they are ready to comply with the Transparency in Coverage final rule in 2022.

Consolidated Appropriations Act

The CAA contains several provisions that require transparency regarding the scope and type of coverage provided and the amount a group health plan pays for coverage. Plans sponsors should focus on the following five key requirements that will affect group health plan operations:

1. *Mental Health Parity Reporting* – Beginning February 10, 2021, plans must analyze compliance with Mental Health Parity and Addiction Equity Act nonquantitative treatment limitations requirements (*i.e.*, limits on benefits that are not tied to specific monetary or visit limits for mental health services; for example, limitations based on medical necessity and exclusions based on failure to complete course of treatment) by completing a written comparative analysis. The CAA and FAQs released on April 2, 2021, describe in detail what factors must be contained in the analysis. Plans are not required to file the analysis with any agency, but state agencies, the Treasury, the Department of Labor (**DOL**), and the Department of Health and Human Services (**HHS**) can request copies of the analysis and are directed to do so with respect to at least 20 group health plans per year beginning in 2021. We understand that the DOL has already made inquiries regarding compliance with this requirement.

2. *Removal of Gag Clauses on Price and Quality Data* – Apparently effective with the signing of the CAA into law (December 27, 2020), health plans may no longer agree to restrictions in provider network contracts that would prevent them from accessing certain cost and quality information and providing it to participants. Among other things, agreements may not place restrictions on:

    - Provider-specific cost and quality of care information and data,
    - Electronic access to de-identified claim information, and
    - The ability to share information with business associates.

    A win for plan sponsors who want to understand the value associated with their provider network, these provisions require that plans have access to specific claims data that show costs related to claims. Providers and carriers/TPAs, however, may still prohibit public disclosure of this information.

3. *Advance EOB Requirement* – The "No Surprises Act" (signed into law as part of the CAA) contains an advance EOB requirement very similar to the cost estimate tool under the Transparency in Coverage final rule (described above). Under the advance EOB requirement, providers must send a good faith estimate of the expected cost of an episode of care to the plan, generally 3 days before service. Once the provider estimate is received, the plan must provide the participant with an advance EOB, which includes several pieces of information that may affect the cost of the service, including:

    - Whether the provider is in-network,

- The good faith estimate made available by the provider,
- The amount the plan will pay and a good faith estimate of the participant's remaining cost sharing obligation, and
- A good faith estimate of the participant's progress toward meeting financial responsibility limits.

Regulations have not yet been issued with respect to the advance EOB requirement, and it is not yet clear if the agencies will attempt to harmonize this requirement with the very similar requirement under the Transparency in Coverage final rule.

4. *Pharmacy Benefits and Drug Cost Reporting* – Beginning December 27, 2021 (and then annually on June 1), a group health plan must report to HHS, DOL, and Treasury certain information regarding the prescription drug benefits it offers. The information requested is plan specific and very detailed, including:

    - The average monthly premiums paid by employers and participants,
    - Total spending on health care services by plan, broken down by hospital costs, primary care costs, specialty care, and prescription drugs,
    - Top 50 most frequently dispensed drugs and identification of the top 50 most expensive drugs, and
    - The premiums paid by the employer and employees for prescription drugs, as well as the effect of any rebates and other remuneration paid by drug companies to the plan on premiums.

    HHS will use the information to issue a publicly available report regarding prescription drug reimbursements, pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under group health plans and the individual insurance coverage market. No plan-specific information will be provided as part of the HHS report.

5. *Disclosure of Compensation to Brokers and Consultants* – The CAA amends Section 408(b)(2) of ERISA to require that "covered service providers" make disclosures to group health plan fiduciaries that include a description of the services provided and the fees collected in exchange for the services. The fee disclosure requirement applies to all group health plans subject to ERISA, and there is no exception for small employer plans. The term "covered service providers" includes all entities that enter into a service contract with a group health plan and reasonably expect to receive $1,000 or more in direct or indirect compensation for:

    - Brokerage services for the selection of insurance products, recordkeeping services, benefits administration, stop-loss insurance, wellness services, disease management, and TPA services, or
    - Consulting services relating to the development or implementation of insurance, PBM services, recordkeeping, medical management, stop-loss insurance, etc.

The disclosure requirement is in effect for contracts entered into (or extended or renewed) after December 27, 2021, and information must be provided far enough in advance of the intended execution of a services contract for a plan fiduciary to act in accordance with its duties. Failure to make the disclosures would prevent the contract from being considered "reasonable" under ERISA, and, therefore, the payment of fees from plan assets would result in a prohibited transaction under ERISA. If a broker or consultant fails to satisfy its disclosure obligations, the plan sponsor may notify the DOL or terminate the contract.

August 19, 2021

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