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Regulations on COVID-19 vaccine and testing requirements issued

By Maureen Gammon and Kathleen Rosenow

On October 28, 2020, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury issued an **interim final rule** (IFR) to implement the requirement under the Coronavirus Aid, Relief, and Economic Security (CARES) Act for group health plans to cover qualifying COVID-19 preventive services without cost sharing. Non-grandfathered group health plans must begin to cover, without cost sharing, both the COVID-19 vaccination and its administration — by either in-network or out-of-network providers — within 15 business days of receiving a recommendation from the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

On the same day, the departments also released a **press release**, **fact sheet**, **frequently asked questions on Medicare billing policies** and **webpage** with COVID-19-related vaccine information.

The IFR also clarifies the requirement under the CARES Act for providers to post the cash price of COVID-19 tests and establishes an enforcement framework for compliance.

The departments will accept comments on the IFR until January 4, 2021.

The IFR is effective November 2, 2020. In general, its provisions will extend until the end of the declared COVID-19 public health emergency (PHE). The PHE declaration was recently extended through January 20, 2021.[1] Note that the requirement in the CARES Act for group health plans to cover a COVID-19 vaccine is permanent and will continue even after the PHE expires.

Coverage of COVID-19 vaccine

- **Plans subject to the COVID-19 vaccine mandate.** The CARES Act requirement to provide first-dollar coverage for COVID-19 preventive services applies to all non-grandfathered private group health plans. It does not apply to grandfathered group health plans; excepted benefits; or short-term, limited-duration insurance.
- **Timing for providing COVID-19 preventive services.** Under the Affordable Care Act's (ACA's) preventive care mandate, a non-grandfathered group health plan typically has at least one year before it must provide first-dollar coverage for a newly issued preventive care requirement or guideline; however, the CARES Act significantly shortens this timing for any qualifying coronavirus preventive service: Non-grandfathered group health plans must cover such a service 15 business days after the USPSTF or ACIP designates it as preventive. The IFR defines

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[1] The secretary of HHS may extend the PHE declaration for subsequent 90-day periods for the duration of the PHE as well as terminate it upon determining that the PHE no longer exists.

qualifying coronavirus preventive services as an item, service or immunization that is intended to prevent or mitigate COVID-19 and that is, with respect to the individual involved, an evidence-based item or service that has in effect a rating of A or B in the current recommendations of the USPSTF, or an immunization that has in effect a recommendation from the ACIP, regardless of whether the immunization is recommended for routine use.

- **Items and services required to be covered.** The IFR clarifies, as it relates to the ACA's preventive services requirement, that non-grandfathered group health plans must provide first-dollar coverage for both the COVID-19 vaccine and its administration, regardless of how the administration is billed, and regardless of whether multiple doses are required. The IFR confirms that the cost of administering the vaccine must still be covered when a third party, like the federal government, pays for the cost of the vaccine itself. If the office visit is not billed separately from the COVID-19 vaccination and the primary purpose of the visit is the delivery of the recommended COVID-19 vaccination, then the group health plan may not impose cost-sharing charges for the office visit.
- **COVID-19 vaccines at out-of-network providers.** Generally, non-grandfathered group health plans are only required to provide first-dollar coverage for in-network preventive services; however, to help ensure that the vaccine is available to as many consumers as possible, the IFR requires that first-dollar coverage be provided for out-of-network services as well.
- **Provider reimbursement of vaccine.** The IFR does not prohibit providers from balance billing vaccine recipients, but in an effort to discourage this, if the group health plan does not have a negotiated rate with a provider, the plan must reimburse the provider for the qualifying coronavirus preventive service "in an amount that is reasonable, as determined in comparison to the prevailing market rates for such service." In the IFR's preamble, the departments indicate that they will consider the amount that would be paid under Medicare for the item or service as being reasonable. Note that providers participating in the CDC's COVID-19 vaccination program must agree not to seek any reimbursement from the vaccine recipient, including through balance billing.

Non-grandfathered group health plans must provide first-dollar coverage for both the COVID-19 vaccine and its administration.

Clarifications on COVID-19 testing requirements

The IFR provides additional guidance related to the COVID-19 testing requirements for group health plans under the Families First Coronavirus Response Act (FFCRA) and the CARES Act. Group health plans must cover COVID-19 diagnostic testing and related items and services without cost sharing during the COVID-19 PHE. If there is no negotiated rate for the diagnostic test, plans must reimburse the provider for the diagnostic test at the cash price for the service, as listed by the provider on a public internet website. The IFR codifies the requirement for providers to post the cash price for the diagnostic test and provides related details. It also lays out how HHS will enforce the requirement, including imposing civil monetary penalties.

Going forward

Plan sponsors of group health plans should review the guidance and be prepared to comply with the requirements within 15 business days after the USPSTF or ACIP recommends a vaccine.

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Election 2020: Preliminary benefit and compensation implications

By Ann Marie Breheny, Stephen Douglas, Kathleen Rosenow, Maria Sarli and Steve Seelig

Based on vote counts at the time of this writing, former Vice President Joe Biden is the presumptive winner of the presidential election, though some results are subject to recount and President Donald Trump's campaign has launched legal challenges in a few states.

In Congress, Democrats will hold a majority in the House of Representatives for the 117th Congress (2021 – 2022). Control of the Senate will be determined by two run-off races that will be held in Georgia on January 5. If Republicans win either of those seats, they will keep their majority for the 117th Congress. If Democrats win both seats, there would be a 50-50 tie and presumptive Vice President Kamala Harris would be the tie-breaking vote, which would give Democrats the majority.

This overview of the benefit-related implications of the 2020 elections is based on an assumed Biden presidency.

General overview

During his campaign, President-elect Biden issued proposals addressing health care and retirement; calling for additional payroll and income taxes on corporations and higher-income taxpayers; supporting paid family, medical and sick leave; proposing an increase in the federal minimum wage; and more. Many of his proposals will require legislative action, and the outlook for such action during the 117th Congress will depend on the outcome of the Georgia elections and the willingness of congressional leaders to work together to approve legislation, among many other factors.

In addition to pursuing legislative action, a Biden administration may use administrative and executive authority to advance its policy priorities. These actions could include new executive orders and agency rules and related guidance as well as actions to revise or rescind some executive orders and regulations issued by President Trump and his administration.

Health care

COVID-19 is expected to be a top priority for President-elect Biden. He has established a task force to help guide public health and economic policies addressing COVID-19. During his campaign, he said he would expand testing; address vaccine distribution; and provide support to state and local governments, small businesses and others. The first of several COVID-19 vaccines could be approved in late 2020 or early 2021, so the new administration would be expected to take steps to facilitate distribution of, and in many cases payment for, the vaccines.

In addition to pursuing legislative action, a Biden administration may use administrative and executive authority to advance its policy priorities.

President-elect Biden campaigned on expanding the Affordable Care Act (ACA) by creating a public option and expanding premium tax credits. Such proposals would require legislative action. President-elect Biden could also focus on proposals that can be achieved through executive or administrative action. For example, he could expand outreach and enrollment through the ACA marketplaces. He suggested that he would reinstate rules prohibiting health care discrimination based on gender identity. President Trump's executive and administrative actions to expand state waivers and expand access to plans that are exempt from some ACA requirements also could be revised or rescinded.

The Supreme Court heard oral arguments on the ACA on November 10 and is expected to issue its ruling in *California v. Texas* by mid-2021. The case centers on whether the individual mandate is unconstitutional without an associated tax penalty, and whether the individual mandate can be separated from the rest of the law if it is found to be unconstitutional. Though oral arguments created a general expectation that the court will generally preserve the law, a decision striking down all, or significant portions, of the law could have wide-ranging implications for individuals, employers, providers and other stakeholders.

Lowering prescription drug costs was under active discussion in Congress and on the campaign trail during 2019 – 2020. President-elect Biden proposed allowing the secretary of Health and Human Services (HHS) to negotiate drug prices for Medicare, ending the tax deduction for pharmaceutical advertising and allowing drug importation if HHS certifies the drugs are safe. He also proposed limiting launch prices

for new prescription drugs that lack market competition and generally limiting price increases for existing drugs to the rate of general inflation. Many of these proposals — and others — have been discussed in Congress. They have not yet been enacted but could return to the agenda during the 117th Congress. Like President Trump, President-elect Biden could use executive or administrative action to address prescription drug costs.

Surprise medical billing was also under discussion in Congress during the 2019 – 2020 term. There was broad agreement among lawmakers that patients should be protected from balance billing by medical providers they do not choose; however, no agreement was reached on how provider payments should be calculated when balance billing is prohibited. President-elect Biden also expressed support during his campaign for ending surprise billing. Congress may renew discussions in 2021, though similar challenges to reaching an agreement will remain. Executive or administrative action on surprise billing is possible.

President-elect Biden said he would prioritize enforcement of state and federal mental health parity laws. He would have the authority to prioritize enforcement of the federal Mental Health Parity and Addiction Equity Act, which is under the jurisdiction of the departments of Labor, Treasury and HHS. In addition, he supports using the government's antitrust authority to address health care industry consolidation.

Action at the state and local level is also possible. Many employer-sponsored plans are governed by ERISA, which preempts numerous state and local laws; however, a patchwork of varying state and local laws could nevertheless create employee communication, reporting or other compliance burdens for employers.

Retirement

Retirement savings could provide an area for possible bipartisan discussion and compromise during the 117th Congress. President-elect Biden issued campaign proposals to "equalize" the tax benefits of defined contribution plans, provide tax incentives to encourage plan sponsorship among small businesses, provide automatic 401(k) programs to give workers without an employer-sponsored plan access to a retirement savings plan, allow catch-up contributions for workers who temporarily leave the workforce to care for family members, and allow survivors of sexual and domestic violence to access their retirement savings.

Retirement savings legislation generally attracts bipartisan support, and bipartisan bills introduced during the 2019 – 2020 legislative term could provide the foundation for discussion during the 2021 – 2022 term. Senators Rob Portman (R-OH) and Ben Cardin (D-MD) sponsored the Retirement Security and Savings Act (S. 1431), and House Ways and Means Committee Chair Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) sponsored the Securing a Strong Retirement Act (H.R. 8696). Representative Neal is expected to chair the Ways and Means Committee in 2021 and 2022, giving him the authority to move the Securing a Strong Retirement Act to a committee vote, though there would be no guarantee for additional action.

There was broad agreement among lawmakers that patients should be protected from balance billing by medical providers they do not choose.

Defined benefit plans received some attention during the 2020 legislative session and could remain under discussion in 2021. The House twice approved provisions to extend amortization of liabilities for single-employer retirement plans to 15 years and to stabilize the interest rate corridor. The provisions were approved as part of the HEROES Act, sweeping legislation addressing COVID-19 relief and economic stimulus. The HEROES Act, however, has not been approved by the Senate. The defined benefit provisions could remain under discussion if negotiations toward a COVID-19 bill resume or in separate retirement security discussions next year.

Regulatory changes for retirement plans could also occur under President-elect Biden's administration. Shortly before the election, the Department of Labor (DOL) finalized a rule that limits the ability of retirement plan sponsors to consider environmental, social and governance (ESG) factors when choosing plan investment options. In addition, the DOL issued a proxy voting proposal that directed fiduciaries to act in accordance with the economic interest of the plan and plan participants based only on factors they "prudently determine will affect the economic value of the plan's investments." In contrast, House and Senate Democrats have supported the ability of sponsors and fiduciaries to consider ESG factors, and a Biden administration could review and possibly modify these rules. In addition, President-elect Biden could order the DOL to review the current fiduciary standard. The Trump administration generally reinstated the fiduciary rule that was in place before the Obama administration issued a stricter rule in 2016. President-elect Biden's administration could seek to modify the current rule and move it closer to the rule issued during the Obama administration.

Tax provisions

President-elect Biden proposed increasing tax rates on higher-income households and on corporations. The Tax Cuts and Jobs Act (TCJA) reduced corporate and individual tax rates and enacted a wide range of other provisions. President-elect Biden criticized the TCJA, saying it benefits higher-income taxpayers and corporations over lower- and middle-income workers, and he proposed repealing some TCJA provisions for higher-income taxpayers. For example, he proposed to reinstate the 39.6% top tax rate (under current law, the top rate is 37%), taxing capital gains as ordinary income for taxpayers with income over $1 million and eliminating the stepped-up basis for inherited assets. He also proposed raising the corporate tax rate to 28% and establishing a 15% minimum rate for some companies. In addition, he has proposed imposing payroll taxes on wages over $400,000. These proposals would be unlikely to see action if Republicans hold the Senate majority.

Executive compensation

With Biden's proposals to increase marginal tax rates, social security taxes and capital gains taxes unlikely to be enacted unless Democrats win both Georgia Senate runoffs on January 5, the focus for executive compensation will turn to the regulatory front — specifically to a Democratic-led Securities and Exchange Commission (SEC). While issues related to COVID-19 are likely to take precedence over any other actions, expect that recent changes to regulations passed along partisan lines will be revisited during a Biden administration. These could include easing the recently imposed restrictions on proxy advisors, proxy access and shareholder proposals, which could increase shareholder influence over corporate operations. As to ESG issues, the SEC also may revisit its principles-based approach to the recently mandated rules for disclosing human capital metrics in company 10-K forms to require specific ESG-related disclosures for all companies.

Workforce proposals

President-elect Biden proposed new benefits and protections for workers, including an increase in the federal minimum wage, overtime protections and paid leave. In terms of the federal minimum wage, President-elect Biden favors increasing it to $15 per hour. He also supports the Paycheck Fairness Act, which addresses wage discrimination by, among other things, narrowing the "factor other than sex" defense to apply only where the wage disparity is based upon a bona fide factor other than sex, such as education, training or experience. These proposals have been pending in Congress for several years, and the prospects for final action during the 117th Congress are not clear.

The first effects of the election results will play out when the current Congress returns to session in December.

A similar outlook faces congressional action on paid leave. President-elect Biden supports paid family and medical leave based on proposals such as the FAMILY Act, which would provide workers two-thirds of their salary (subject to a cap) for up to 12 weeks of qualifying leave. He also supports the Healthy Families Act, under which employees would earn an hour of paid sick leave for every 30 hours worked, up to seven paid sick days per year. These proposals have been pending in Congress for several years and would face an uncertain outlook during the next Congress.

President-elect Biden said he would ensure that workers receive the overtime protections to which they are entitled. In addition, he proposed restoring the broad definition of "joint employment" and stopping employers from misclassifying workers (including "gig" workers) as independent contractors. President-elect Biden could attempt to implement such proposals through executive and administrative action.

Looking ahead

The first effects of the election results will play out when the current Congress returns to session in December. This "lame duck" session will involve lawmakers who have served during the 2019 – 2020 legislative term, including some who will not return for the 117th Congress. During this session, Congress must approve legislation to fund the government starting after December 11 and may extend some expiring tax provisions and health care programs. Congress could also resume negotiations over a COVID-19 relief and stimulus bill, though action is not guaranteed.

In addition to completing work for the 2019 – 2020 legislative term, Congress and the new administration will be organizing and planning for 2021. In Congress, some committees that have primary jurisdiction over employee benefit and tax issues will have new committee leadership, even if Republicans retain the majority for 2021 – 2022. Term limits imposed on Republican committee chairs will require Senator Charles Grassley (R-IA) to give up his chair at the Finance Committee. He could be succeeded by Senator Mike Crapo (R-ID). Senator Lamar Alexander (R-TN), who has chaired the Health, Education, Labor and Pensions (HELP) Committee, is retiring and could be succeeded by Senator Richard Burr (R-NC). If Democrats gain the majority, Senator Ron Wyden

(D-OR) would be expected to chair the Finance Committee and Senator Patty Murray (D-WA) would likely chair the HELP Committee. New committee leadership could bring new legislative priorities to these committees.

During its first days, the new Biden administration is likely to place a hold on rulemaking and guidance that has not taken effect. Such action has become typical so that the new administration can review guidance projects. President-elect Biden will also be organizing his administration and announcing nominees for cabinet and other important appointed positions. Cabinet members and many other nominees will require Senate approval.

The 117th Congress will commence next January, and President-elect Biden will be sworn in on January 20, 2021.

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Supreme Court hears oral arguments in ACA constitutionality case

By Rich Gisonny and Kathleen Rosenow

Oral arguments in the Affordable Care Act (ACA) individual mandate case *(California v. Texas)* took place as scheduled via teleconference on November 10, 2020. This case challenges the constitutionality of the individual mandate given that the tax penalty was eliminated by Congress in 2017 (effective in 2019). It also raises the question of whether the entire law should be struck down if that provision is unconstitutional (due to the lack of a severability clause in the ACA). A decision is expected by spring/summer of 2021.

Following are several highlights from the oral arguments:

- **Full court:** Oral arguments were heard by the full court of nine justices, including Amy Coney Barrett, President Trump's most recent appointee. This means there cannot be a tie vote.
- **Standing:** The court spent a good amount of time on the question of whether the plaintiffs have "standing" to sue (i.e., has the party suffered an injury that is fairly traceable to the defendant's conduct and is likely to be redressed, or remedied, by a favorable decision). If the court determines that no plaintiff has standing, it could dismiss the case without ruling on substantive constitutional questions.
- **Constitutionality:** Discussion on the constitutionality of the individual mandate focused on whether the absence of a penalty converted the mandate from a permissible "choice" (i.e., purchase health coverage or pay a tax) into an unconstitutional "command." The court also discussed whether the mandate can still be considered a tax (albeit a $0 tax).
- **Severability:** As to the issue of whether the rest of the ACA can be severed if the mandate is determined to be unconstitutional, several court members, including Chief Justice John Roberts and Justice Brett Kavanaugh, suggested that it wasn't the Supreme Court's place to invalidate the entire law, and that the fate of the mandate shouldn't determine the continued viability of the rest of the law. This is noteworthy, particularly with respect to Justice Kavanaugh, since he has been considered by some observers likely to vote to strike down the ACA.

It is difficult to predict exactly how the court will rule on this case; however, based on the oral arguments, it appears that a majority of the justices may be resistant to striking down the entire ACA.[1]

[1] For a discussion of possible outcomes in the case, see "**Potential impact of Supreme Court changes on the ACA**," *Insider*, October 2020.

Departments finalize transparency in health coverage rule

By Anu Gogna and Ben Lupin

The Departments of Health and Human Services (HHS), Labor and Treasury have issued **final regulations** (along with a **news release** and **fact sheet**) on transparency in health coverage required under the Affordable Care Act (ACA). The final regulations are generally consistent with the proposed regulations[1] that were released in November 2019 in that they include two approaches to make health care price information accessible.

The final rule will start taking effect in 2022, but its full implementation will be delayed until 2024.

These regulations are in response to President Trump's **Executive Order** on Improving Price and Quality Transparency. Essentially, health insurance issuers (for fully insured plans) and third-party administrators (for self-insured plans) will be required to provide plan participants with an explanation of benefits *prior to* receiving care.

Under the final regulations most non-grandfathered[2] group health plans[3] or health insurance issuers offering health insurance coverage in the individual and group markets must make available certain disclosures:

- **To the public, including such stakeholders as consumers, researchers, employers and third-party developers:** Three separate machine-readable files must include detailed pricing information *for plan years that begin on or after January 1, 2022:*
  - The first file must show negotiated rates for all covered items and services between the plan or issuer and in-network providers.
  - The second file must show both the historical payments to, and billed charges from, out-of-network providers. Historical payments must have a minimum of 20 entries to protect consumer privacy.
  - The third file must detail the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

The final rule will start taking effect in 2022, but its full implementation will be delayed until 2024.

- **To participants, beneficiaries and enrollees (or their authorized representatives):** Personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, must be provided through an internet-based self-service tool and in paper form upon request.
  - An initial list of 500 shoppable services, as determined by the departments, must be available via the internet-based self-service tool *for plan years that begin on or after January 1, 2023.*
  - The remainder of all items and services will be required for these self-service tools *for plan years that begin on or after January 1, 2024.*

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[1] See "**Proposed regulations designed to increase health care cost transparency**," *Insider*, November 2019.

[2] The term "grandfathered" is defined in the **ACA** and is used in regulations and other agency guidance to refer to certain group health plans and health insurance coverage existing as of March 23, 2010 (the date the ACA was enacted).

[3] The final rules do not apply to excepted benefits, such as limited-scope dental or vision plans, or to account-based group health plans, such as health reimbursement arrangements (HRAs) (including individual coverage HRAs) and health flexible spending accounts.

Q&A: Final rule on health care transparency

By Maureen Gammon, Anu Gogna and Ben Lupin

The departments of Health and Human Services (HHS), Labor and Treasury's **final regulation** on health care transparency applies to certain group health plans and health insurance issuers offering group or individual health insurance coverage.[1] The following Q&A is intended to assist employer group health plan sponsors in understanding the upcoming compliance requirements.

The rule will essentially make health insurance issuers...and TPAs...provide plan participants with an explanation of benefits prior to receiving care.

Q. Why was the rule issued?

The rule was issued pursuant to President Trump's **executive order** on improving price and quality transparency. It significantly expands the information that certain group health plans must disclose to health plan participants, beneficiaries and enrollees. The rule will essentially make health insurance issuers (for fully insured plans) and third-party administrators (TPAs) (for self-insured plans) provide plan participants with an explanation of benefits *prior* to receiving care.

Q. Is this the same rule that applies to hospitals?

No. The health care transparency rule is intended to *complement* a similar hospital transparency rule issued earlier by HHS. That rule, also issued pursuant to President Trump's executive order, directed HHS to require hospitals to post standard charge information based on negotiated rates for common or shoppable items or services. The **final hospital transparency rule** issued in November 2019 was quickly **challenged** in court by the American Hospital Association and **upheld** by the district court. The hospitals appealed to the U.S. Court of Appeals for the District of Columbia Circuit, and oral arguments were held on October 15, 2020. If not set aside by the D.C. Circuit, the hospital transparency rule will go into effect on January 1, 2021.

Q. What plans are subject to the final health care transparency rule?

The disclosure requirements in the final rule would apply to non-grandfathered[2] group health plans and health insurers in the individual and group markets. This includes level-funded arrangements, multiple employer welfare arrangements, plans with alternative contracting and payment model structures (such as health maintenance organizations and accountable care organizations) and "grandmothered" plans. This Q&A refers to the plans covered by this rule as "impacted plans."

Q. What plans are excluded from the final rule?

The final health care transparency rule does not apply to grandfathered health plans, excepted benefits (including limited scope dental or vision benefits), short-term limited duration insurance, health care sharing ministries, health reimbursement arrangements or other account-based group health plans (e.g., health flexible spending accounts).

Q. When does the rule go into effect?

The rule will be *phased in* over three years, from 2022 through 2024; however, employers are encouraged to begin discussing a plan for compliance with their insurers, TPAs and pharmacy benefit managers (PBMs) as soon as possible. Gathering the required information and building the systems will take both time and coordination prior to 2022.

Q. What will need to be done for plan years that begin on or after January 1, 2022?

The final regulation will require that impacted plans *make available to the public* (including stakeholders such as consumers, researchers, employers and third-party developers) three separate machine-readable files (which will need to be updated monthly and made available on the insurer's or plan's website free of charge) that include detailed pricing information.

The three files that will need to be publicly disclosed consist of:

1. **In-network information:** A file showing negotiated rates for all covered items and services between the plan or issuer and in-network providers
2. **Out-of-network information:** A file showing both the historical payments to, and billed charges from, out-of-network providers

[1] See "**Departments finalize transparency in health coverage rule**," *Insider*, November 2020.

[2] The term "grandfathered" is defined in section 1251(e) of the **Affordable Care Act** and is used by the IRS, DOL, Centers for Medicare & Medicaid Services, and HHS to refer to certain group health plans and health insurance coverage existing as of March 23, 2010 (the enactment date of the Affordable Care Act).

3. **Prescription drug information:** A file detailing the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level (note this third file was not included in the proposed rule but was added by the final rule)

Q. What must be done for plan years that begin on or after January 1, 2023?

The final rule will require that impacted plans and health insurance issuers make available to participants, beneficiaries and enrollees (or their authorized representative) personalized out-of-pocket cost information, and the underlying negotiated rates, for an initial list of 500 shoppable services through an internet-based self-service tool. This information can be requested in paper form, limited to information for up to 20 providers per request, and must be mailed (or shared by phone or email) within two business days of the request.

Q. What must be done for plan years that begin on or after January 1, 2024?

The personalized out-of-pocket cost information for the remainder of all covered items and services under the plan will be required to be provided via these self-service tools (or in paper form, by request).

Q. What information needs to be included in these personalized disclosures?

The final rule outlines seven content elements that a plan or insurer must disclose, in plain language, upon request:

1. Estimated cost-sharing liability
2. Accumulated amounts
3. In-network rates
4. Out-of-network allowed amounts
5. Items and services content list for a bundled payment
6. A notice of prerequisites to coverage (note: limited to concurrent review, prior authorization, and step-therapy or fail-first protocols)
7. A disclosure notice **(model available)**

Plans or insurers may disclose additional information, such as quality information or other metrics, and alert consumers searching for one service (e.g., surgery) to the potential need to search for another service (e.g., anesthesia or pathology).

Because plans and insurers will be providing this information in advance of the care, the departments make it clear that the cost-sharing data are only estimates and will not necessarily reflect the amounts that the individual is ultimately charged.

The cost of setting up the required systems is likely to be passed through to the employer plan sponsors and could be significant.

Plans and insurers have flexibility to create these tools, but the tool should enable users to search for cost-sharing information from a specific in-network provider or all in-network providers using a billing code (such as a CPT code) or a descriptive term (for example, "rapid flu test"). The tool should be able to account for different cost sharing based on multi-tier provider networks, dosages and place-based settings (such as an outpatient facility versus a hospital setting). In-network providers should also be easily filtered based on geographic proximity and estimated cost-sharing liability. The tool should also enable searches for out-of-network services and providers.

Q. Who can request this information?

This cost-sharing information needs to be available upon request to plan participants, beneficiaries and enrollees (or their authorized representative). The final rule clarifies that disclosures of cost-sharing information are only required to individuals who are *enrolled* in the plan or coverage.

Q. Can employer plan sponsors rely on insurance carriers and TPAs to comply with the final rule?

It depends. Fully insured group health plans can enter into a written agreement with an insurer or other third party (such as a health care clearinghouse) to provide the necessary information. In those circumstances, the insurer or third party (not the plan sponsor) will be responsible for a failure to provide full or timely cost-sharing information.

The protection described above does not apply to self-insured group health plan sponsors that contract with a TPA (including a PBM for prescription drug information sharing). The *plan sponsor* (not the TPA nor PBM) will be liable for any failure to comply with the final rule.

Q. What are the implications of the final rule on employer plan sponsors?

- **Cost increases.** The departments estimate in the preamble to the final rule that compliance will cost the industry billions of dollars. The cost of setting up the required systems is likely to be passed through to the employer plan sponsors and could be significant. Whether this is a one-time cost or spread over a period of years will be something to watch as the market for these tools evolves. The alternative of employer plan sponsors building these

tools on their own with information from the carriers is unlikely to be cost-efficient or desirable for most employers. Furthermore, employers are unlikely to have the required charge data nor the capability of collecting the required data in-house and building the required tool to share that information. As a result, employers will likely need to pay a third party for compliance.

- **Written agreements for disclosing the information.** As stated previously, under the final rule, fully insured group health plans can enter into a written agreement with an insurance carrier or other third party (such as a health care clearinghouse) to provide the necessary information. In those circumstances, the insurer or third party (not the employer plan sponsor) will be responsible for a failure to provide full or timely cost-sharing information. This same protection does not apply to self-insured group health plan sponsors that contract with a third party. The employer plan sponsor and not the third party will be liable for failure to comply; therefore, plans and insurers will need to contract with third parties to develop and update the various tools needed for the disclosure of information (including not only insurance carriers/TPAs but also PBMs). Because employers sponsoring self-insured plans would still be responsible for any violations of the final rule, employers will likely need to discuss indemnification via the written agreement(s) with these third parties and with qualified legal counsel.
- **Coordinating with multiple parties.** Depending on the specific setup of the group health plan, employer plan sponsors are likely going to need to coordinate the gathering and disclosure of different information from multiple vendors. The "items or services" under the final rule include encounters, procedures, medical tests, supplies, drugs, durable medical equipment and fees (including facility fees). This is likely to involve multiple insurance carriers and TPAs and will also require written agreements among the various parties setting forth each party's responsibilities, deadlines for compliance, updating of the information and so on.

Q. Who oversees enforcement of the final rule?

State insurance regulators will be the primary enforcers of the transparency rule for fully insured plans, while the DOL will enforce the final rule for group health plans subject to ERISA (e.g., self-insured plan). The Treasury will oversee certain church plans, and HHS will oversee non-federal governmental plans.

The preamble to the final rule appears to anticipate [legal] challenges.

The departments also include a "good faith safe harbor" for when a plan or insurer, acting in good faith, makes an error or omission so long as it corrects the information as soon as possible. The same is true if the plan's or insurer's website is temporarily inaccessible. Plans and insurers must replace the incorrect information and may need to notify those affected by the error and the correction (including posting an online notice of how long it will take to correct the error). Plans and insurers that rely on information from a third party will be held harmless for errors unless the plan or insurer should have known that the information from the third party was incomplete or inaccurate.

Q. Will the rule be challenged in court? Will President-elect Biden support the rule?

This rule will almost certainly face legal challenges. The preamble to the final rule appears to anticipate these challenges, and the rule also includes a severability clause (so if one part of the rule is thrown out, the remainder of the law can still stand). Furthermore, the delayed implementation timeline provides employers, insurance carriers and other interested parties with additional time to lobby for changes (or extensions).

This rule is a result of the Trump administration leveraging provisions of the ACA in an attempt to expand transparency in the health insurance market, happening at the same time as the administration argues that the entire law is invalid in *California v. Texas* (the Supreme Court case arguing the individual mandate is unconstitutional and that the entire law must fall).[3] While comments on the proposed rule reflected general support for more transparency, it will be interesting to see if a new administration will support this rule in its final form.

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[3] See "**Potential impact of Supreme Court changes on the ACA**," *Insider*, October 2020.

2021 inflation-adjusted limits for retirement and employee benefit plans announced

By Cindy Brockhausen, Gary Chase and Anu Gogna

On October 26, the IRS released **Revenue Procedure 2020-45,** which contains the 2021 tax year inflation adjustments for a number of income tax benefit-related provisions, including health flexible spending arrangements, qualified transportation fringe benefits, qualified adoption assistance programs and eligible long-term care premiums. It also includes the indexed dollar amounts for the federal income tax-related standard deduction and tax rate tables.

That same day, the IRS also released **Notice 2020-79,** which contains the qualified retirement plan limits for 2021. These limits restrict the contributions that can be made to, and benefits that can be paid from, qualified retirement plans as well as the compensation that can be used when determining benefits.

On October 13, the Social Security Administration announced that the **maximum taxable wage base** on annual wages subject to Social Security taxes will increase to $142,800 in 2021 (up from $137,700 in 2020); in **Revenue Procedure 2020-32** – released earlier this year – the IRS provided the inflation-adjusted limits relevant to health savings accounts (HSAs).

The table below includes select limits for 2021 and compares them with the 2020 limits. These limits potentially impact the design, administration, communication and tax reporting for retirement and benefit-related plans.

Health flexible spending arrangements (FSAs) (general and limited purpose)	**2020**	**2021**
Maximum annual health FSA salary reduction contribution	$2,750	**$2,750**
Maximum annual health FSA carryover of unused amounts from the prior plan year for plans that permit carryover	$500	**$550**
Qualified transportation fringe benefits	**2020**	**2021**
Monthly limitation amounts		
Transit pass and commuter highway vehicle (combined)	$270	**$270**
Qualified parking	$270	**$270**
Qualified adoption assistance	**2020**	**2021**
Maximum per adoption income tax exclusion		
Child with special needs (regardless of actual expenses)	$14,300	**$14,440**
Other adoptions	$14,300	**$14,440**
Adjusted gross income (AGI) tax exclusion phaseout		
Phaseout begins	$214,520	**$216,660**
Phaseout complete	$254,520	**$256,660**
Dependent care assistance (including FSAs)[1]	**2020**	**2021**
Maximum annual dependent care assistance benefit		
Individual or a married couple filing jointly	$5,000	**$5,000**
Married individual filing separately	$2,500	**$2,500**
Qualified retirement plan limits	**2020**	**2021**
Maximum recognizable compensation	$285,000	**$290,000**
Highly compensated employee (HCE)	$130,000	**$130,000**
Section 415 benefit limits		
Defined benefit plans	$230,000	**$230,000**
Defined contribution plans	$57,000	**$58,000**
Limit on pre-tax elective deferrals		
Under age 50	$19,500	**$19,500**
Age 50 and over	$26,000	**$26,000**

continued

Qualifying longevity annuity contract (QLAC)	**2020**	**2021**
Investment limit	$135,000	**$135,000**
Social Security taxable wage base	**2020**	**2021**
Taxable wage base	$137,700	**$142,800**
Eligible long-term care (LTC) premiums	**2020**	**2021**
Annual limitation on LTC premiums includible as medical care		
Age before close of tax year		
Up to 40	$430	**$450**
41 to 50	$810	**$850**
51 to 60	$1,630	**$1,690**
61 to 70	$4,350	**$4,520**
Over 70	$5,430	**$5,640**
Standard deduction	**2020**	**2021**
Filing status		
Married individuals filing jointly	$24,800	**$25,100**
Heads of households	$18,650	**$18,800**
Unmarried individuals	$12,400	**$12,550**
Married individuals filing separately	$12,400	**$12,550**
Health savings accounts (HSAs)	**2020**	**2021**
Individual coverage		
Maximum annual HSA contribution	$3,550	**$3,600**
Minimum annual deductible for high-deductible health plan (HDHP)	$1,400	**$1,400**
Maximum annual out-of-pocket expenses for HDHP	$6,900	**$7,000**
Family coverage		
Maximum annual HSA contribution	$7,100	**$7,200**
Minimum annual deductible for HDHP	$2,800	**$2,800**
Maximum annual out-of-pocket expenses for HDHP	$13,800	**$14,000**
Catch-up contributions[2] (for individuals attaining age 55 by December 31 until enrolled in Medicare)	$1,000	**$1,000**

[1] The dependent care assistance limits under Internal Revenue Code section 129 are not adjusted for inflation; these benefit limits can only be adjusted by a legislative amendment to section 129.
[2] The HSA catch-up contribution amount for participants attaining age 55 by December 31 of the tax year is not adjusted for inflation; any change would require statutory amendment.

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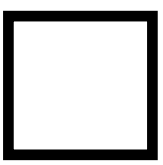

DOL releases final 2020 MHPAEA self-compliance tool

By Maureen Gammon and Kathleen Rosenow

The Department of Labor (DOL) has released the final **2020 MHPAEA Self-Compliance Tool**, incorporating the changes it proposed in June[1] with some minor modifications and clarifications. The tool is intended to help group health plans evaluate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

While no compliance obligations have been added since the tool was last updated in 2018, the final 2020 version integrates recent DOL guidance, adds compliance examples, provides best practices for internal compliance strategies for group health plans, provides more "warning signs" that may require additional review to ensure MHPAEA compliance and provides a tool for comparing group health plan reimbursement rates to Medicare reimbursement rates.

Specifically, the 2020 self-compliance tool makes the following changes in response to comments received:

- **Integration of recent guidance:** The final tool clarifies how methods for establishing provider reimbursement rates must comply with MHPAEA's requirements for nonquantitative treatment limitations (NQTLs). For example, the tool clarifies that requirements for NQTLs apply to methods for establishing both in-network and out-of-network provider reimbursement rates. The DOL has also added an introduction to the tool for comparing provider reimbursement rates to Medicare rates that explains the tool's purpose and how it might be used.
- **Best practices for establishing an internal compliance plan:** Although an internal compliance plan is not required under the MHPAEA, the 2020 tool includes the following language recommending clear protocols and documentation of internal monitoring and compliance reviews that are delegated to other entities:

  > Plans and issuers that delegate management of mental health/substance use disorder (MH/SUD) benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.

Plan sponsors should review the self-compliance tool to better understand the MHPAEA compliance requirements.

- **Addition of warning signs:** The DOL added and omitted specific warning signs and clarified others that were included in the proposed update. Specifically, a warning sign for potential noncompliance regarding establishment of provider reimbursement rates has been added. The proposed tool listed "Inequitable reimbursement rates established via a comparison to Medicare" and "Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes" as provider reimbursement warning signs. The final tool also lists "Consideration of different sets of factors to establish reimbursement rates" (meaning a plan generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits). The DOL also removed the warning sign related to drug screenings.

Going forward

The DOL is required to update the tool in 2022 but will likely issue other MHPAEA guidance before then.

Plan sponsors should review the self-compliance tool to better understand the MHPAEA compliance requirements. Full MHPAEA compliance testing should be considered if a plan sponsor has not tested in the past or has changed its plan design since last testing.

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[1] See "**DOL proposes update to MHPAEA self-compliance tool**," *Insider*, July 2020

Federal court rules in United Behavioral Health claims denial case

By Maureen Gammon and Kathleen Rosenow

A class action lawsuit in California against United Behavioral Health (UBH) for its handling of behavioral health claims from 2011 to 2017 ended with a decision issued by the federal District Court for the Northern District of California in the remedies phase. In 2019, the court ruled in **Wit v. United Behavioral Health** that UBH had violated ERISA's fiduciary duties by wrongfully using its internally developed coverage determination guidelines (CDGs) and level of care guidelines (LOCGs) to deny care, applying criteria that were more restrictive than the generally accepted standard of care for behavior conditions.

The court's remedies decision, issued on November 3, 2020, requires UBH to reprocess the more than 60,000 denied claims, using court-approved criteria of generally accepted standards of care. Although the case was decided under ERISA and not under the Mental Health Parity and Addiction Equity Act (MHPAEA), the outcome benefits those individuals with mental health and substance use disorders (MH/SUD) and the adjudication of their claims under employer group health plans.

The lawsuit only directly affects claims of individuals who joined the class action, and the reprocessing of their claims, which is ongoing; however, UBH is permanently enjoined from using its own behavioral health CDGs and LOCGs that were at issue in *Wit*.

Background

ERISA requires plan administrators and others who exercise any discretionary authority or discretionary control over the management of the plan and disposition of plan assets to act as fiduciaries. The primary responsibility of fiduciaries is to run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses. In **Wit v. UBH**, the court held that UBH (which also operates as OptumHealth Behavioral Solutions) breached its fiduciary duties by developing and employing flawed medical necessity criteria for behavioral health services.

The case concerned MH/SUD claim denials by UBH under certain employer group health plans that all required, as a condition of coverage, that the requested treatment be consistent with generally accepted standards of care. Typically, the claims were for chronic MH/SUD conditions, which UBH denied based on its own LOCGs and CDGs, instead of national evidence-based guidelines for outpatient, intensive outpatient and residential treatment of MH/SUDs that have been developed by nonprofit, clinical specialty organizations, such as the American Society of Addiction Medicine (ASAM). The court found that UBH's medical-necessity criteria were designed to approve coverage solely for "acute" episodes or crises, such as when individuals are actively suicidal or suffering from severe withdrawal. The court ruled for the claimants, stating that under generally accepted standards of care, chronic and comorbid conditions should be effectively treated, even when those conditions persist, respond slowly to treatment, or require extended or intensive levels of care. Apparently, UBH did not file an appeal of this decision.

The [decision] requires UBH to reprocess the more than 60,000 denied claims, using court-approved criteria of generally accepted standards of care.

August 2020 ruling

In 2019, the court issued its ruling on the facts of the case but deferred ruling on the question of whether the diagnosis-specific UBH CDGs listed in the trial exhibits incorporated UBH's LOCGs. In August, the same California federal district court **determined** that all of UBH's CDGs did incorporate its internally developed LOCGs. This meant that *all* the claim denials that were part of the class action lawsuit were determined using standards that are more restrictive than the generally accepted standards of behavioral health care and are subject to the remedies applied by the court.

Remedies

On November 2, 2020, the same federal judge that decided the 2019 case and made the August 2020 ruling decided the **remedies phase** of the case and ordered:

- **Permanent injunction.** UBH is permanently prohibited from using any of the internally prepared CDGs and LOCGs that were at issue in the case when making coverage-related determinations.

- **Injunctive relief related to what criteria may and may not be used to make future coverage determinations.** The court imposed a 10-year injunction (which could possibly be reduced to five years) during which UBH must make any and all coverage-related determinations under ERISA-governed plans about whether services are consistent with generally accepted standards of care. The court found that UBH is in danger of a recurrent violation of its 2019 ruling, even though UBH stated that it is faithfully applying ASAM, Level of Care Utilization System (LOCUS) and other third-party guidelines to make coverage determinations.
- **Injunctive relief requiring training of clinicians and top-level executives.** The court ordered that UBH clinicians and top-level executives (current and future hires) be trained to ensure they understand their obligations under ERISA when making coverage decisions.
- **Court-ordered supervision.** The court also ordered the appointment of a special master to oversee UBH's compliance with both reprocessing and prospective injunctive relief.
- **Notices.** The court ordered UBH to notify the class members of the court's liability findings and the remedies it awarded.
- **Reprocessing.** Most important, after UBH's employees complete court-ordered training on generally accepted standards of behavioral health care, UBH will be required to reprocess over 60,000 mental health and substance use disorder treatment claims that it illegally denied from 2011 to 2017. UBH is required to reevaluate only whether the proposed treatment at the requested level of care was consistent with generally accepted standards of care. The court provided procedures on how the claims are to be reprocessed, reimbursements to claimants made (if the claim is approved) and the provisions of interest payments on such reimbursements.
- **No retaliation.** In reprocessing the claims, UBH is prohibited from: 1) denying a request on any ground other than the lack of medical necessity or the clinical inappropriateness of the services; 2) reevaluating any coverage determination made with respect to a class member other than the remanded adverse benefit determinations; and 2) seeking to recoup or offset, from the class member or his or her provider(s), any amounts UBH pays pursuant to the court order.

Going forward

Group health plan sponsors should review the court decisions and discuss them with their legal counsel and behavioral health third-party administrators (TPAs) to ensure that the TPAs are administering their plans appropriately. Group health plan sponsors should also consider conducting an in-depth review of their plans for compliance with MHPAEA, especially regarding nonquantitative treatment limitations.

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New California law requires employers to collect and report pay data

By Stephen Douglas, Rich Gisonny, Laura Rickey and Lindsay Wiggins

California recently enacted a new law (**SB 973**) that requires covered employers to collect and report pay and hours worked data for each calendar year no later than March 31 of the following year. These new reporting requirements aim to reduce gender and racial pay gaps. The California pay data report is similar to the now-rescinded Component 2 of the federal EEO-1 form that would have required employers to collect and report similar comparable information.

The California law applies to employers with 100 or more employees; however, it is uncertain whether that means 100 or more employees in California or nationwide. It is also unclear, for now, whether the required data must be reported only with respect to California employees.

FAQs

Q. When are reports required to be filed?

The new California law requires employers to submit their first report, covering 2020 calendar-year data, by March 31, 2021; however, due to the scope of the required data, employers will need to start preparing now to file a timely report. Future reports will need to be filed by March 31 of each subsequent year.

Q. Where are the reports filed?

The reports are filed with the California Department of Fair Employment and Housing (DFEH). Employers with multiple establishments are required to submit a report for each one as well as a consolidated report that includes all employees.

The law defines an "establishment" as "an economic unit producing goods or services." Further clarification of this term may be needed.

Q. What data must be collected and reported?

The report to DFEH must include two categories of information, with data submitted in a searchable and sortable format:

1. Covered employers must report the number of employees by race, ethnicity and sex in each of the federally identified job categories. These categories are executive or senior-level officials and managers, first or midlevel officials and managers, professionals, technicians, sales workers, administrative support workers, craft workers, operatives, laborers and helpers, and service workers. Employers will count employees in these groups by creating a "snapshot pay period" (as described below).
2. Covered employers are required to report the number of employees by race, ethnicity and sex whose annual earnings fall within each of the pay bands used by the U.S. Bureau of Labor Statistics in the Occupational Employment Statistics survey. The 12 pay bands span from $19,239 and under to $208,000 and over. Employers must submit annual W-2 earnings for each employee in the "snapshot pay period" (as described below), regardless of whether the employee worked a full year. Employers must also report total hours worked by each employee within a given pay band during the reporting year. Reporting the total number of hours worked for exempt employees, or any employees who do not file time sheets or track the specific number of hours worked, will be challenging. It is possible that regulatory guidance will reflect that employers can use a standard number of hours as a default (e.g., 40 hours per week for full-time employees and a lower number for part-time employees) as was done for Component 2.

Note that this information is nearly identical to the information that would have been reported under the federal EEO-1 Component 2 had the Equal Employment Opportunity Commission (EEOC) not suspended such requirement after President Trump took office.

Q. Which employers are covered by the new law?

The new law applies to private employers with 100 or more employees that are required to file the EEO-1 form under federal law. Based on informal comments we received from a California legislative aide, the intent of the new law may have been to cover only employers that have at least 100 employees *in California.* Some attorneys, however, believe

The new law applies to private employers with 100 or more employees that are required to file the EEO-1 form under federal law.

that employers likely will have to count employees located outside of California because this is how some other employment statutes in the state, with a similar employer coverage definition, have been interpreted in the past. In the absence of official guidance on this issue, employers will need to discuss with their legal counsel how to calculate the 100-employee threshold.

Q. Which employees are included in a report?

Employers must submit information based on a snapshot taken from the end of any pay period between October 1 and December 31. The report must account for and include all employees who were active as of that "snapshot pay period," regardless of whether the employee worked for the employer the entire calendar year. "Employee" is defined to mean "an individual on an employer's payroll, including a part-time individual, whom the employer is required to include in an EEO-1 Report and for whom the employer is required to withhold federal social security taxes from that individual's wages." It is unclear whether this definition would include employees who work outside of California for a California employer. Some commentators have questioned whether the state has legal authority to require California employers to report data on *non-California* employees, and argue that a narrower scope of the data collection should prevail. In the absence of clarifying guidance, employers should consult with their legal counsel regarding this issue.

Q. What happens with the data?

The law requires the DFEH to make the reports available to the California Division of Labor Standards Enforcement (DLSE) upon request and to maintain the pay data reports for a minimum of 10 years. It also authorizes the DFEH to seek an order requiring non-reporting employers to comply. In addition, the law authorizes the DFEH to "receive, investigate, conciliate, mediate, and prosecute complaints" alleging unlawful wage discrimination practices. The law prohibits any officer or employee of the DFEH or DLSE from making public any individually identifiable information obtained from the report before certain investigations or enforcement proceedings; it also requires the Employment Development Department to provide the DFEH with the names and addresses of all businesses with 100 or more employees.

Q. What concerns have employers raised about the pay data reports?

The new California law faces the same criticisms as the federal EEO-1 Component 2. For instance, some employers have argued that the collection of W-2 earnings will unnecessarily open the door to increased scrutiny and investigations because of the limited opportunities employers have to explain legitimate non-discriminatory reasons for pay disparities (e.g., education, training, experience, tenure, merit). Similarly, the new law does not take into account certain other differences between jobs, such as eligibility for overtime, commissions and bonuses, or employees working less than the entire year or being promoted during the year. Employers may provide "clarifying remarks," but it is unclear how effectively that will protect employers from misguided enforcement efforts. Employers are also concerned about data privacy as well as the significant amount of time and resources that will be needed to complete a report that may produce data of limited value.

Q. How should employers start preparing?

Employers should begin determining how they will collect the necessary data by:

- Ensuring that jobs are correctly classified according to the **EEOC guidelines**
- Comparing and linking existing pay bands to those used by the Bureau of Labor Statistics
- Determining how to report hours worked for exempt employees

In addition, employers should consider conducting a pay equity analysis to identify existing wage differences between employees doing "substantially similar work," evaluate the reasons for the differentials and, where necessary, make adjustments.

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Year-end amendment deadline approaching for some NQDC plans

By Bill Kalten and Drew Kusner

Special transition relief provided by the IRS that allows employers to remove mandatory delay-in-payment provisions from some nonqualified deferred compensation (NQDC) plans ends on December 31, 2020.

Normally, a company cannot simply eliminate a provision requiring a delay in payment for NQDC plan benefits accrued to date, because doing so would impermissibly accelerate payment of those benefits. The IRS addressed this issue in **proposed regulations** and provided special transition relief that allows employers to remove mandatory delay provisions by December 31, 2020.

Background

Some nonqualified defined benefit and defined contribution plans contain a provision that permits (or may require) benefit payments to "covered employees" under Internal Revenue Code (IRC) section 162(m) to be delayed if the employer's deduction for such payments would not be allowed under that IRC section. Section 162(m) limits the allowable deduction

The IRS...provided special transition relief that allows employers to remove mandatory delay provisions by December 31, 2020.

for compensation paid to covered employees of publicly held corporations to $1 million per year.

Such delay-in-payment provisions in NQDC plans are authorized under IRC section 409A regulations if certain conditions are met, including that the delay must apply to *all* scheduled payments that could be delayed under the exception and all payments to similarly situated employees must be treated on a reasonably consistent basis. Benefit payments delayed under this provision must be made in the first year the employer's deduction would no longer be subject to the limit. In the past, this has typically been no later

than when the employee separated from service and ceased to be a covered employee.

However, changes made to section 162(m) by the Tax Cuts and Jobs Act (TCJA) complicated this issue. The TCJA changed the definition of "covered employee" so that once an employee becomes a covered employee, he or she will always be a covered employee, even after employment is terminated. As a result, if an employer's NQDC plan includes a provision that provides for a delay in payment until it is deductible under section 162(m), the payment may be delayed indefinitely.

The 409A regulations also provide an exception that permits payments to covered employees of compensation that qualify as short-term deferrals to be made after the applicable two-and-a-half-month period[1] and continue to qualify as such if the employer reasonably believes that its deduction for such payment, if made as scheduled, would not be permitted under section 162(m).

Special transition relief

For *NQDC plans providing employers with discretion to delay,* the employer will simply not exercise discretion and pay amounts as originally scheduled. The IRS has indicated that an employer may delay the scheduled payment of "grandfathered"[2] amounts without delaying the payment of "non-grandfathered" amounts without violating the uniformity and consistency requirements mentioned above.

For *NQDC plans requiring a delay,* a significant period of time may pass before payment of the entire NQDC plan benefit would be deductible, as discussed previously. Further, the entire amount might never become deductible if the employee dies and the payment (or remaining amount due) is payable at death. The IRS indicated in the preamble of the proposed regulations that employers may remove this type of provision from a NQDC plan without penalty by December 31, 2020. The plan amendment may be limited to amounts not grandfathered under section 162(m) (i.e., payment of grandfathered amounts may continue to be delayed). In any event, if the amended plan requires the employer to make any payment before December 31, 2020, then the payment must be made by December 31, 2020.

Going forward

Companies should review their NQDC plan documents and, particularly if mandatory delay-in-payment provisions are included, determine whether those previsions should be removed.

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[1] The applicable two-and-a-half-month period is the period ending on the 15th day of the third month following the later of the end of the employee's first tax year in which the right to the payment is no longer subject to a substantial risk of forfeiture, or the 15th day of the third month following the end of the employer's first tax year in which a right to the payment is no longer subject to a substantial risk of forfeiture.

[2] For more information on "grandfathered" amounts, see "**Key takeaways from recently proposed 162(m) regulations**," *Insider*, February 2020.