Employee Benefits During the Pandemic: 2021 Trends and Developments

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COVID-19 Vaccines & Returning to Work

Coverage of COVID-19 Testing Under Health Plans

- Mandatory coverage of COVID testing is required as preventive care under group health plans – without cost-sharing, pre-authorization, or other medical management techniques
  - For individualized diagnosis or treatment of COVID-19
  - Even if asymptomatic, or no known or suspected exposure
  - Limited exception to mandatory coverage by plan if strictly for general workplace safety or public health surveillance

Vaccine Coverage Under Health Plans

- Mandatory coverage of all COVID-19 vaccines is required, without cost-sharing, pre-authorization, or other medical management techniques, regardless of the individual's priority for the vaccine
- Use of incentive programs to encourage vaccination
  - Extra pay/bonus – taxable
  - Extra paid time off
  - Gift cards

Wellness Program Implications of Incentives

- Incentives may be considered "health contingent" wellness programs
- EEOC recently withdrew proposed regulations on wellness programs, issued shortly before the end of the Trump administration, focusing on how large incentives can be to meet ADA/GINA standards of voluntariness
- HIPAA nondiscrimination rules remain in effect
    - 30% limit on all incentives; 50% limit with tobacco incentives
    - Need to provide reasonable alternatives – *i.e.*, participating in COVID-19 safety training

Returning to Work

Current Status of the COVID-19 Vaccine Rollout

- Most states are in Phase 1b or 1c
  - **1b:** Typically, frontline essential workers; people aged 65+; people aged 16 - 64 with a high-risk medical condition or disability that increases their risk of severe illness from COVID-19; and people living in correctional facilities, homeless shelters and migrant labor camps
  - **1c:** Adults age 65-74; essential workers in lab services, agriculture, manufacturing, postal service, etc.
  - Guidance on who qualifies in each phase is a state health department determination
- State and local health departments have rolled out interactive websites to assist with registration, vaccine tracking and locating, and other information
  - Maryland: https://covidlink.maryland.gov/content/vaccine/
  - Virginia: https://www.vdh.virginia.gov/covid-19-vaccine/

Public Confidence in the COVID-19 Vaccine

- "'Herd immunity', also known as 'population immunity', is a concept used for vaccination, in which a population can be protected from a certain virus if a threshold of vaccination is reached…The percentage of people who need to have antibodies in order to achieve herd immunity against a particular disease varies with each disease." The herd immunity thresholds for measles and polio require about 95% and 80% of the population to be vaccinated, respectively.*

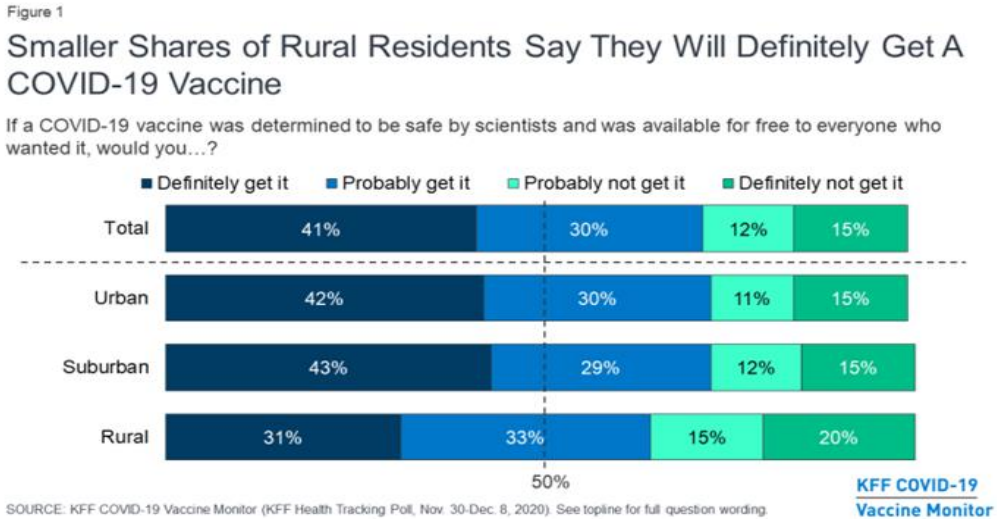
- Falling short of the herd immunity threshold is concerning, and it raises questions about the necessity of mandatory vaccination policies

*Source: World Health Organization, Coronavirus Disease (COVID-19): Herd Immunity, Lockdowns and COVID-19

https://www.who.int/news-room/q-a-detail/herd-immunity-lockdowns-and-covid-19#:~:text=Herdimmunityisachievedby,withoutmakingussick

Public Confidence in the COVID-19 Vaccine

- 71% of the public claim they would "definitely or probably get a vaccine for COVID-19 if it was determined to be safe by scientists and available for free to everyone who wanted it."*



*Source: Liza Hamle, Ashley Kirzinger, Cailey Muñana, and Mollyann Brodie, KFF COVID-19 Vaccine Monitor: December 2020, https://www.kff.org/coronavirus-covid-19/report/kff-covid-19-vaccine-monitor-december-2020/

Requiring Vaccines in the Workplace

- Employers have a duty under OSHA to ensure that their workplace is free from "recognized hazards that are causing or are likely to cause death or serious physical harm to employees." 29 U.S.C. § 654
- States have also imposed their own safety requirements on employers.
  - Virginia's Department of Labor and Industry issued its Final Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, effective January 13, 2021
- Employers should consider:
  - ✓ How closely together employees work
  - ✓ How much exposure employees have to customers or other members of the public
  - ✓ Whether employees have exposure to food products or other consumables in a manufacturing, restaurant or retail setting

Requiring Vaccines in the Workplace

- ***Requiring*** individuals to get vaccinated, however, has legal and ethical considerations
  - Legally, an employer can have a mandatory vaccination policy for its employees as long as exemptions are provided for religion and disability
  - Ethically, to date, the COVID-19 vaccines in use have only received Emergency Use Authorization (EUA), not FDA licensure, which means recipients must be informed that they may refuse the vaccine
- Liability concerns
  - Workers' compensation claims for adverse effects from COVID-19 vaccinations
- Regardless of whether an employer decides to mandate vaccinations or encourage them, employees should continue to abide by social distancing and face covering requirements until herd immunity is achieved and our public health officials have declared it safe to no longer require protective measures

Exemptions from the Mandatory COVID-19 Vaccine - Disabilities

- Employees with disabilities under the Americans with Disabilities Act (the "ADA") may be entitled to an exemption from any mandatory vaccination requirement. However, if an employee's disability under the ADA prevents him/her from receiving the vaccine, an employer **does not have to provide a reasonable accommodation** if:
    - There is not an accommodation available;
    - The accommodation would present an undue hardship to the employer; or
    - The employee would pose a direct threat to the health and safety of other employees
- The factors an employer should use to determine whether an unvaccinated employee poses a direct threat to the health or safety of individuals in the workplace are: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm

Exemptions from the Mandatory COVID-19 Vaccine - Religion

- An employee may have an exemption under Title VII of the Civil Rights Act of 1964 for a sincerely held religious belief, practice, or observance [that] prevents him/her from taking the COVID-19 vaccine
  - As a general rule, employers should assume that an employee's request for a religious accommodation is based on a sincerely held religious belief
  - If the employer has an objective basis to question the sincerely held religious belief, practice, or observance, the employer is justified in requesting additional supporting information from the employee
  - The employee must cooperate, and if the employee refuses, he may not be entitled to the accommodation
- However, the religious exemption **does not** extend to political opposition to the COVID-19 vaccination
- An employer need not provide a reasonable accommodation if such accommodation poses an undue hardship – that is, when there is more than a *de minimis* cost to the operation of the employer's business

Best Practices

- The CDC, EEOC, and FDA all recommend that employers encourage their employees to get COVID-19 vaccinations
- Employers should:
  - ✓ Consider hosting a vaccination clinic (contact your local health department for guidance)
  - ✓ Be flexible in HR policies. Establish leave policies and support transportation to off-site vaccination clinics
  - ✓ Use promotional posters and flyers to advertise vaccination offerings in the community
  - ✓ Post articles in company communications about the importance of COVID-19 vaccination and where to get the vaccine in the community

Trends in Health & Welfare Plan Design

Flexible FSA Changes Now Permitted

Overview of FSA Relief

- Temporary options for relief from unused FSA forfeitures

OPTIONAL

- Must be added by plan amendment
- Plan amendments may be retroactive

- Unlimited carryover **or** extended 12-month grace period
- Spend-down of unused health FSA benefits after mid-year termination of participation
- Reimbursement of dependent care expenses for children who have turned 13
- Mid-year election changes to adjust FSA contributions without change in status

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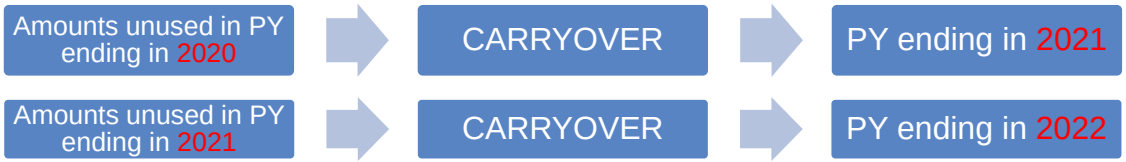
Enhanced FSA Carryover *or* Extended Grace Period

- May allow carryover of some or all of the unused health and dependent care FSA amounts remaining at end of PYs ending in 2020 and 2021



- May extend grace period for unused health and dependent care FSA amounts remaining at end of PYs ending in 2020 or 2021

Enhanced FSA Carryover *or* Extended Grace Period

IRS Notice 2021-15 Clarifications

- Enhanced carryover and extended grace period do not impact FSA election caps
- Ongoing coverage in general-purpose FSA adversely impacts HSA eligibility for the entire period of coverage; consider flexibility to preserve HSA eligibility *(e.g.,* restricting reimbursement of unused amounts for limited-purpose FSA expenses)
- Cannot have both carryover and grace period for same benefit in same year
- Can add carryover or grace period or switch from current design
- Can treat health FSA and dependent care FSA differently
- Can impose restrictions (*e.g.,* limit time of grace period, impose caps on amounts, require continued FSA participation)
- Only report amounts once for Box 10, W-2 reporting and only count amounts once for nondiscrimination testing

Health FSA Spend Down

May allow health FSA participants who cease participation mid-year during **2020 or 2021 calendar years** to have continued access to unused amounts for qualifying expenses incurred through the end of the **plan year** in which participation ended, including an extended grace period

- ✓ Access can be limited to contributions through date participation ended
- ✓ Must still offer COBRA if participation ended due to COBRA qualifying event
- ✓ Can limit access to a shorter period than end of PY
- ✓ Consider HSA eligibility - ongoing coverage in general-purpose FSA adversely impacts HSA eligibility for the entire period of coverage

Dependent Care FSA: Children Turning 13

May allow limited period for continued reimbursement of dependent care expenses after child turns 13

- Applies to:
  - last plan year during which the regular enrollment period ended on or before January 31, 2020 ("Year 1"), and
  - the next plan year ("Year 2"), but only for unused grace period amounts from the 2020 PY or unused amounts carried over into the 2021 PY
- Available if child turns 13 in either "Year 1" or "Year 2" – but in "Year 2" only to the extent of unused amounts from "Year 2" – and for expenses incurred before child turns 14
- Identification of "Year 1" is tied to the enrollment period, not the PY
- Unused amounts remaining at end of "Year 2" cannot continue to be used to reimburse expenses for 13-year-olds

Mid-Year FSA Election Changes

May allow employees to make a mid-year change in FSA election amounts without a change in status in PY ending in 2021

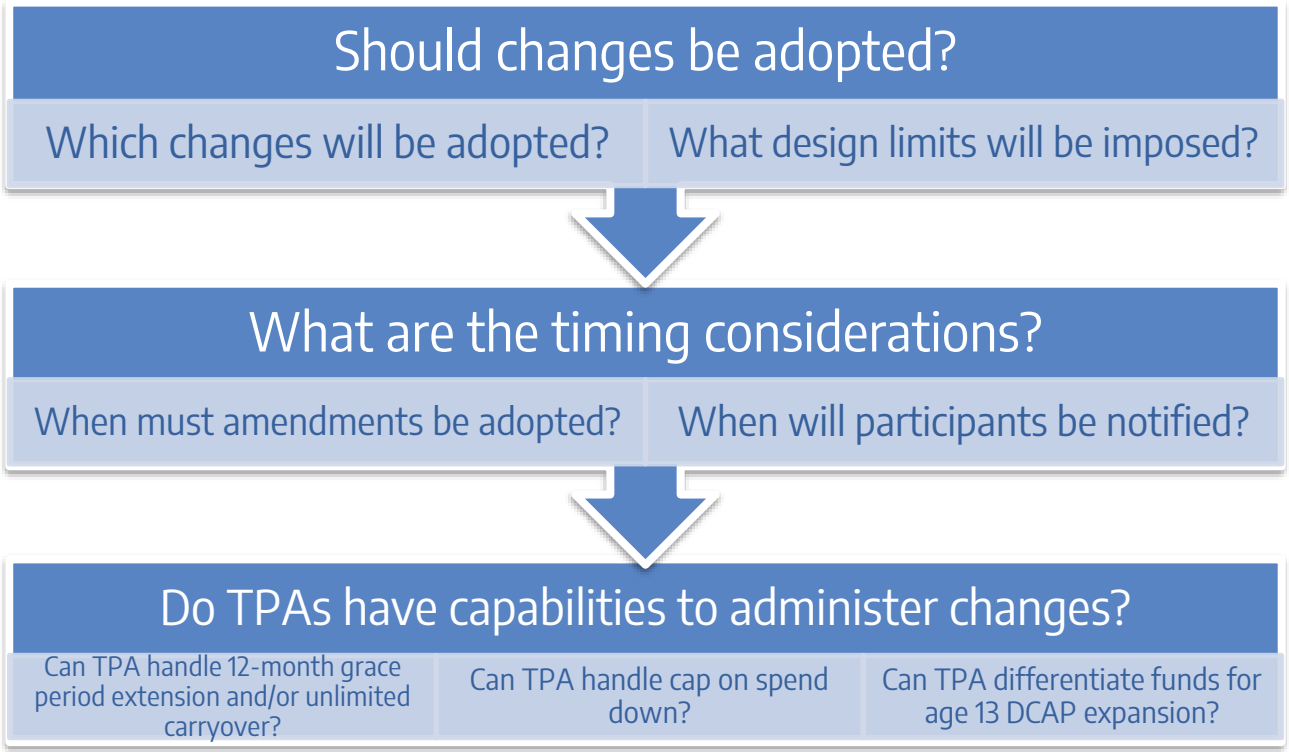
- ✓ Change in election must be prospective
- ✓ Change may not exceed applicable dollar limitation (*e.g.*, $2,750 health FSA annual maximum in 2021)
- ✓ Can permit multiple election changes during 2021, but not required to do so
- ✓ Can impose limits on timing or frequency of changes
- ✓ Can preclude election reductions below reimbursements already received
- ✓ May permit election changes to opt-in (and access carryover or grace period)
- ✓ May use election to terminate participation and become HSA-eligible for remainder of year

Additional Election Changes

IRS Notice 2021-15 allows additional election changes for PY ending in 2021 related to group health coverage (medical, dental, vision)

- Make new election for coverage on a prospective basis, if initially declined
- Revoke an existing election and make a new election to enroll in different coverage (including from self-only to family coverage)
- Revoke existing coverage (drop coverage), so long as employee attests in writing that the employee is enrolled, or immediately will enroll, in other health coverage

Action Items



Other Plan Design Trends

Popular Health and Welfare Plan Design Updates

- Expanding virtual or telehealth programs
- Enhancing mental health support, such as employee assistance programs or additional services
- Adding or expanding voluntary benefits
- Adding emergency back-up childcare support
- Increasing cost-sharing for plan expenses such as deductibles, premiums or co-payments
- Augmenting services for managing high-cost claims, including specialty pharmacy claims

Considerations in Health & Welfare Plan Administration

Mental Health Parity and Addiction Equity Act

MHPAEA Analysis Documentation & Disclosure Requirements

- The Mental Health Parity and Addiction Equity Act ("MHPAEA") prohibits group health plans that provide mental health/substance use disorder (MH/SUD) benefits from applying "financial requirements" or "treatment limits" to those benefits that are more restrictive than the "predominant" financial requirement or treatment limit that applies to "substantially all" medical/surgical (M/S) benefits
- As of February 10, 2021, Departments of Health and Human Services, Labor, and Treasury are required to request that self-insured group health plans and health insurance issuers provide documents demonstrating compliance with MHPAEA nonquantitative treatment limit ("NQTL") requirements
    - Plans and insurers must perform and document analysis of design and application of NQTLs on MH/SUD benefits and M/S benefits in the same "classification" in plan terms and in operation

Nonquantitative Treatment Limits

- NQTLs - affect scope or duration of benefits and are not expressed numerically, such as medical necessity requirement, experimental/investigational treatment limitation, standards for determining provider admission in network, including reimbursement rates
- Examples of NQTLs:
  - medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
  - formulary design for prescription drugs;
  - network tier design;
  - standards for provider admission to participate in a network, including reimbursement rates;
  - plan methods for determining usual, customary, and reasonable charges;
  - fail-first policies or step therapy protocols;
  - exclusions based on failure to complete a course of treatment; and
  - restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

MHPAEA Benefit Classifications

- Benefits under MHPAEA are analyzed based on benefit classifications required by the rule:
  - Inpatient, in-network
    - Sub-classification for multiple network tiers
  - Inpatient, out-of-network
  - Outpatient, in-network
    - Sub-classification for office visits
    - Sub-classification for multiple network tiers
  - Outpatient, out-of-network
    - Sub-classification for office visits
  - Emergency care
  - Prescription drug

Warning Signs of Noncompliance

- The DOL has provided examples of plan provisions that warrant additional investigation to determine if the limits are also applied to M/S benefits and if so, if they are being applied to MH/SUD and M/S benefits in a manner that complies with MHPAEA
  - Preauthorization & Pre-service Notification Requirements: Plan/insurer requires preauthorization for all mental health and substance use disorder services
  - Fail-First Protocols Progress Requirements: For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency
  - Probability/Likelihood of Improvement: For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement
  - Written Treatment Plan: For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider
  - Residential Treatment Limits: Plan/policy excludes residential level of treatment for chemical dependency

MHPAEA Disclosure Requirement

Upon request, plans and insurers must provide:

- ✓ Specific NQTL terms and a description of all MH/SUD or M/S benefits to which each term applies in each benefit classification
- ✓ Factors and evidentiary standards used to determine that NQTLs will apply to MH/SUD and M/S benefits
- ✓ Comparative analyses demonstrating that the process, strategies, evidentiary standards, *and* other factors used to apply NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, those used to apply NQTLs to M/S benefits in the benefits classification
- ✓ Specific findings and conclusions reached by the group health plan or insurance issuer with respect to the coverage, including any results of the analysis

Action Items

- ✓ For self-insured plans, conduct NQTL analysis if one has not been conducted
  - If NQTL analysis has been conducted, confirm analysis includes statutorily required elements
  - Confirm that updated analysis is conducted after plan design changes
- ✓ Establish timeline for conducting regular compliance analysis
- ✓ Ensure record retention and information
- ✓ Review/amend service provider contracts to include MHPAEA compliance requirements and NQTL analysis
- ✓ Respond promptly to detected compliance issues
- ✓ Be prepared to report data and results and respond promptly to requests for information and data

Final Rule on Transparency in Health Coverage for Group Health Plans

- Issued October 29, 2020, and designed to provide patients with sufficient information to accurately estimate healthcare costs:
  - Requires public cost disclosure for plan years beginning on or after 1/1/22, consisting of in-network file, out-of-network file and prescription drug file
  - Requires individual cost sharing liability disclosure, consisting of cost sharing information that must be provided upon request by participant or beneficiary, and a self-service tool
    - Phased in over time: partial compliance for plan years beginning on or after 1/1/23; and full compliance for plan years beginning on or after 1/1/24
  - Not applicable to (1) HRAs, including ICHRAs and QSEHRAs; (2) grandfathered plans; (3) excepted benefits; and (4) standalone retiree health plans

Consolidated Appropriations Act, 2021 and No Surprises Act

- Continuation of enhanced disclosure and increased transparency rules imposed on group health plans, intended to protect consumers. Effective plan years on or after 1/1/22:
  - Advanced Explanation of Benefits (EOB) before scheduled care, including estimates of cost-sharing, the amount of plan benefits, and whether the provider is in-network or out-of-network; plan must also provide online and telephonic price comparison tools
  - Up-to-date provider directories
  - ID cards must include in-network and out-of-network deductibles and out-of-pocket maximums
  - Out-of-network providers must provide good faith estimated amount for all services to be provided within expedited timeframes (*e.g.*, 1 day if scheduling 3 days out); upon request

Surprise Medical Billing

	Participating Provider		Non-participating provider
Provider's billed charge	$7,100	Provider's billed charge	$7,100
Allowed amount	$4,600	Allowed amount	$4,600
Participant's cost share (assume $1,000 deductible and 20% coinsurance)	$1,720	Participant's cost share (assume $1,000 deductible and 20% coinsurance)	$1,720
Plan pays	$2,880	Plan pays	$2,880
Balance bill	$0	Balance bill	$2,500
Total participant responsibility	**$1,720**	Total participant responsibility (cost share plus balance bill)	**$4,220**

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Surprise Billing Protections

- Preventing surprise medical bills; effective for plan years on or after 1/1/22:
  - In-network cost sharing (*e.g.,* deductibles, co-pays and co-insurance) applies to certain out-of-network services and are treated as in-network costs
  - Applies to group health plans, health insurance issuers and certain health care providers
  - Providers are not permitted to balance bill any amount in excess of the in-network cost sharing
  - Does not fully preempt existing state requirements with respect to state-established payment amounts; states can also continue to pass surprise billing laws and regulations

Surprise Billing Structure

- **Emergency services**: Out-of-network emergency services and facility charges in a hospital emergency room or a freestanding emergency department. Also includes post-stabilization observation and inpatient or outpatient stays associated with the emergency visit if the patient's plan covers the services, and the provider does not opt-out.
- **Non-emergency services provided by out-of-network providers at in-network facilities**:
  - Exception exists if the patient received notice and provides consent, but the exception is not available for "ancillary services" or services arising from unforeseeable, urgent medical needs
  - "Ancillary services" include (but are not limited to) anesthesiology: pathology; radiology; diagnostic services
  - NOT covered are elective procedures at out-of-network facilities
- **Air ambulance services**: Similar, but not identical, rules apply to out-of-network air ambulance services; plan must provide detailed reports on claims to federal government

Independent Dispute Resolution

- Within 30 days of service, the plan or issuer must either deny the claim or determine the claim is covered; if covered, the payment must be paid directly to the out-of-network provider
- After initial payment or denial, there is a 30-day cooling off period for negotiations before a party may utilize the IDR process; if no agreement is reached, parties have 4 days to initiate the binding IDR process with a certified IDR entity
- "Baseball style" IDR process applies to disputes between providers and the plan/issuer
- IDR entity determines the amount of payment for qualified IDR item or services; may not consider U&C, amount that otherwise would have been billed, or a governmental rate (*e.g.*, a percentage of Medicare)
- 90-day cooling period follows a determination for the party that submitted request for same type of item or service
- All fees paid by party whose offer is not chosen; split fees if parties reach a settlement before determination

Prescription Drug Reporting

- Effective **December 27, 2021,** and by June 1 for each year thereafter, group health plans and issuers must submit reports to HHS, DOL and IRS disclosing the following:
  - Number of enrollees, participants and beneficiaries for each plan year
  - Each state covered
  - Top 50 brand prescription drugs most frequently dispensed for claims paid and total number of claims paid for each drug
  - Top 50 costliest drugs in annual spending and the amount spent
  - Top 50 drugs with greatest expenditure increase over previous year
  - Total spending by plan on health care services, including cost type and spending by the plan and enrollees
  - Average monthly premium
  - The impact on premiums from rebates

Gag Clause Prohibition

- Plans are prohibited from entering into agreements with providers, TPAs or others that would directly or indirectly restrict the plan from:
  - Disclosing provider-specific cost or quality of care information through a consumer engagement tool or any other means to the plan sponsor, enrollees or eligible individuals
  - Electronically accessing de-identified information
  - Accessing certain per claim information such as financial information, provider information, service codes and sharing data with a HIPAA business associate
  - There may be reasonable restrictions on public disclosure

  Annual attestation to HHS will be required

Broker and Consultant Disclosures

- Effective for contracts beginning, renewed or extended on or after December 27, 2021, "brokerage" and "consulting" service providers will need to comply with new disclosure requirements
  - ERISA Section 408(b)(2) exception for prohibited transactions with a party in interest as long as the arrangement is reasonable, the services are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid
  - Retirement plan service providers are already subject to DOL regulations requiring disclosure of direct and indirect compensation they receive
  - The CAA amends Section 408(b)(2) to substantially mirror the regulatory requirements applicable to retirement plans; it applies broadly to group health plans, including health FSAs, many EAP programs, and HRAs. There is no group health plan size threshold, and excepted benefits are **not** exempt
  - Only if the service provider receives $1,000 or more; further guidance needed on the types of service providers covered

Broker and Consultant Disclosures

- Disclosures must include:
  - Description of services provided
  - A statement on whether the service provider will serve as an ERISA fiduciary
  - A description of all direct compensation the service provider reasonably expects to receive in connection with the services
  - A description of all indirect compensation that the service provider reasonably expects to receive, including compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan
  - A description of the arrangement under which the indirect compensation is paid
  - Identification of the services for which indirect compensation will be received
  - Identification of the payer of the indirect compensation
  - A separate description of any compensation that is set on a transaction basis (*e.g.,* commissions) that will be paid among the service provider, affiliate, or subcontractor
  - A description of any compensation that the covered provider will receive upon termination of a contract or arrangement

Action Items

- ✓ Stay tuned for implementing regulations from HHS, the Department of Labor and the Department of Treasury
- ✓ Review plan documents and Summary Plan Descriptions; amend as necessary
- ✓ Review vendor contracts with TPA, insurance carrier and PBM; amend to comply with rules requiring disclosure of in-network, out-of-network and prescription drug files on the plan's website; price-comparison tool; provider directories; consider indemnification provisions to protect the plan
- ✓ For self-insured plans, amend agreements with TPAs to address reporting requirements for air ambulance services; advanced EOBs
- ✓ Analyze impact on Plan costs due to balance billing protections for participants
- ✓ Coordinate reporting requirements on pharmacy benefits and drug costs with issuer, carrier, PBM
- ✓ Review provider contracts and ensure that they do not contain impermissible restrictions on disclosure of provider-specific cost and quality information; may need to renegotiate existing agreements
- ✓ Identify any broker or person or entity that consults to any group health plan; determine if they are a covered service provider
- ✓ Review any compensation disclosures provided to determine whether the service provider receives direct or indirect compensation and if so, how much
- ✓ Review, analyze and maintain the compensation disclosures to determine that the compensation arrangement is reasonable

Benefit Changes in the American Rescue Plan

Temporary COBRA Subsidies

- Assistance-eligible individuals can have 100% of COBRA premiums subsidized for coverage periods between 4/1/2021 – 9/30/2021; not included in individual income; employers get reimbursed by government through payroll tax credits
  - "Assistance-eligible individual" means any COBRA qualified beneficiary (employee or dependent), where the COBRA event was an involuntary termination of employment or reduction in hours
- Subsidy ends earlier if maximum COBRA period ends or if individual becomes eligible for another group health plan or Medicare
  - Individuals have an affirmative obligation to notify employer or face risk of monetary penalties (greater of $250 or 110% of subsidized COBRA premiums)

New COBRA Elections

- If an individual already had an involuntary termination of employment or reduction in hours within the last 18 months, and as of 4/1/21 did not timely elect COBRA or dropped COBRA, they have a new 60-day election period following the date that they receive a new COBRA notice, with coverage effective 4/1/21
- Employers may (but are not required to) give assistance-eligible individuals the right to change elections to other plan options that have the same or lower cost premiums; they have 90 days to enroll after notice of this option
- Action steps (with model notices expected within 30-45 days after enactment):
  - ✓ Send updated COBRA notices to assistance-eligible individuals to describe the subsidy and new elections
  - ✓ Send notice of expiration before the premium subsidy expires

Expanded Dependent FSA Limits & Executive Compensation Limits

- Increase in annual dependent care FSA limit from $5,000 to $10,500 for 2021 only (for married filing jointly)
  - For married filing separately, increase from $2,500 to $5,250
  - Employer can amend plan retroactively, as long as amended by 12/31/2021 and operated consistently with amended terms
- Beginning in 2027, the number of executives in publicly-traded companies, for whom compensation over $1M is not deductible, increases by 5

Pension Funding Relief

- **For single employer pension plans**
  - Permits funding shortfalls to be amortized over 15 years (not 7), beginning in 2022 plan year
- **For multiemployer pension plans**
  - Can retain their 2019 funding status for one plan year beginning between 3/1/20-3/1/22
  - If in yellow or red zone, can extend rehabilitation or funding improvement plan period by 5 years
  - Can amortize investment losses incurred in one or both plan years ending after 2/29/20 over 30 years (not 15)
  - Special financial assistance program with PBGC, through 12/31/2025, for plans expected to become insolvent

Trends in Retirement Plans

A Year Into COVID: Surprising 401(k) Plan Statistics

- The average 401(k) plan balance increased 8% from a year ago, and one-third of 401(k) participants increased their savings rate in 2020*
  - Financial markets did not collapse; strong stock market
  - No widespread suspension of employer match: 5% of 401(k) plan sponsors reduced or suspended the company matching contributions in 2020, with small plans with less than 50 participants being 3x as likely to suspend matching contributions than plans with 5,000 or more participants**
  - Most plans added COVID-related distributions, but only 7% reported that more than 5% of participants used this option**

* Fidelity's Q4 2020 Retirement Analysis
** "COVID-19 Is Not A Retirement Story" by the Center for Retirement Research at Boston College, February 2021

Looking Ahead Post-COVID: Ways to Increase Retirement Savings

- Despite the overall stability of retirement accounts, 43% of workers feel increased stress about their financial situation as compared to before the pandemic, and participants approaching retirement had inadequate balances prior to the pandemic
- Plan sponsors should consider the following to help participants increase savings; restatement of prototype plans by 7/31/22 creates an opportune time to introduce plan design changes (subject to limits on mid-year amendments for safe harbor plans)
  - Increase deferral rates: Auto-enrollment is key to increased participation
  - Stretch auto-increase escalator cap to 15%: 64% of deferral increases in Q4 2020 were due to auto increase programs, and those that took out COVID-related withdrawals may need to boost retirement savings in coming years *
  - Add Roth feature: Increasingly popular with younger participants; in last 5 years plans offering Roth has increased 33%*
  - Offer investment education and financial wellness support: Exercise caution about whether 401(k) plan assets are paying for financial wellness services

* Fidelity's Q4 2020 Retirement Analysis

DOL Issues Missing Participant Guidance

- On January 12, 2021, DOL issued three pieces of guidance regarding missing participants:
  - "Best Practices" document
  - Compliance Assistance Release 2021-01
  - Field Assistance Bulletin 2021-01
- Issued during final days of Trump Administration, so may be reviewed by Biden Administration, but may survive intact, since consistent with policy decisions from both parties
- One or more "red flags" indicate a potential missing participant problem (*e.g.,* more than small number of missing/nonresponsive participants; more than small number of terminated vested participants who have reached normal retirement and not started receiving pension benefits; incomplete contact information; absence of policies for handling returned mail and uncashed checks)

Best Practices

- ✓ Checking related plan and employer records (*e.g.*, payroll records or records maintained for another plan) for participant, beneficiary and emergency contact information
- ✓ Checking with designated plan beneficiaries and emergency contracts in the employer's records for updated contact information
- ✓ Using free online search engines, public records databases (*e.g.*, for real estate taxes), obituaries and social media
- ✓ Using a commercial locator service, a credit-reporting agency or internet search tool
- ✓ Attempting to contact via USPS certified mail or private delivery services with similar tracking features to the last known mailing address
- ✓ Attempting contact via other available means, such as email address, telephone and text numbers, and social media
- ✓ Using death searches (*e.g.*, Social Security Death Index) and redirecting communications to beneficiaries
- ✓ Contacting colleagues of missing participants, or publishing a list of "missing" participants on the company's intranet, in email notices to existing employees, in communications with other retirees who are already receiving benefits, or with a union's local offices
- ✓ Registering missing participants on public and private pension registries with privacy and cybersecurity protections (*e.g.*, National Registry of Unclaimed Retirement Benefits), and publicizing the registry through emails, newsletters and other communications

Disaster-Related Relief under 2021 Appropriations Act

- **Consolidated Appropriations Act, 2021 – Disaster Related Distributions & Loan Relief**
  - Participants who maintain a principal residence within a federal disaster area, and who suffered an economic loss to that residence as a result of the disaster, may be able to take up to $100,000 from a retirement plan without 10% early distribution penalty
    - Federal disaster must have occurred between 12/28/2019 – 12/27/2020
    - President must have declared federal disaster between 1/1/2020 – 2/25/2021
    - Distribution must be made before 6/25/2021
  - Increased loan amounts (through 6/25/2021), and a temporary suspension of loan repayments are also permitted
  - Plan amendments needed by 12/31/2022; coordinate with third-party administrator

Cybersecurity Concerns

- Recent uptick in lawsuits related to fraudulent plan distributions
- Plan sponsor, trustee, recordkeeper, administrator, and committee will all be scrutinized whenever cyberattack or fraudulent plan distribution
- Increased vulnerability with many people working from home, including recordkeepers and in-house benefit professionals
- No cases have been decided on the merits yet
  - *Berman v. Estee Lauder*: Settled in March 2020 for undisclosed amount
  - *Leventhal v. MandMarblestone Group:* Moved pass motion to dismiss; court permitted the plan administrator to assert counterclaims against recordkeeper for contribution indemnity
  - *Bartnett v. Abbot Laboratories:* Plan sponsor and administrator were granted motion to dismiss (leaving suit against recordkeeper), but plaintiff filed amended complaint
- Implement best practices:
  - ✓ Communicate to participants responsibility to use strong passwords and authentication steps
  - ✓ Monitor recordkeepers
  - ✓ Include on agenda for fiduciary committees to demonstrate fiduciary due diligence

Biden Administration: What to Expect

- **Regulatory freeze**: White House Chief of Staff issued a memo directing agencies to place a hold on all recently issued rules and regulations
  - DOL fiduciary rule requiring "best interest" considerations when providing advice to participants on rollovers: Scheduled to take effect February 16, 2021; will likely be delayed and subject to additional review
  - Interim final rule on lifetime income illustrations: Scheduled to take effect September 18, 2021, but will likely be further reviewed
  - DOL final fiduciary proxy voting rule: Became effective January 15, 2021, but DOL announced will not be enforced
  - DOL final rule on financial factors in selecting plan investments (the "ESG Rule"): Became effective January 12, 2021, but DOL announced will not be enforced

Biden Administration: What to Expect

- **SECURE Act 2.0**: Bipartisan supported retirement plan legislation; not yet enacted
  - Requiring auto enrollment, beginning at 3% and increasing annually by 1% until reaching 10%, people can opt out
  - Increasing catch-up limit to $10,000 starting at age 60
  - Permitting matching contributions for qualified student loan payments
  - Permitting de minimis financial incentives (gift cards) for contributing to a plan
  - Increasing RMD start date from age 72 to age 75; decreasing RMD penalty tax from 50% to 25%; exempting accounts less than $100,000 from RMDs
  - Eliminating requirement that sponsors advise "unenrolled participants" about plan changes; however, notices of eligibility must be provided 1x/year
  - Changing rules for long-term part-time workers, who would now become eligible for deferrals after 2 years
  - Providing grace periods to correct auto enrollment & auto escalation errors, without corrective contributions, if found within 9 ½ months after end of plan year in which the mistake was made
  - Giving sponsors latitude about whether to recoup plan overpayments; providing that rollovers of excess amounts are not in jeopardy; and expanding EPCRS overall
  - Directing DOL to modify regulations so that TDF with a mix of asset classes can be benchmarked against a blend of broad-based securities and would be reset once a year
  - Directing Treasury, DOL & PBGC to report on how to simplify reporting & disclosure; and authorizing PBGC to manage a new database that would support efforts to find missing participants and allow participants to find lost retirement accounts

Additional Resources

- **Remote working Policy**

  CDC's Resuming Business Toolkit: https://www.cdc.gov/coronavirus/2019-ncov/community/resuming-business-toolkit.html

- **2021 Compliance Calendar**

  https://static1.squarespace.com/static/5a3a78a21f318d7787c74348/t/600ef72251b66723ef418bf3/1611593506564/January+19%2C+2021+-+2021+Compliance+Calendar.pdf

- **Isler Dare, P.C. COVID-19 Employer Resources**

  https://www.islerdare.com/covid19

- **Isler Dare, P.C. Employee Benefits Update: IRS Releases Guidance and Additional Relief for FSAs under the Consolidated Appropriations Act, 2021 with Notice 2021-15**

  https://isler-dare.squarespace.com/s/March-9-2021-Notice-2021-15.pdf

- **Isler Dare, P.C. Employee Benefits Update: American Rescue Plan Act 2021**

  https://isler-dare.squarespace.com/s/March-12-2021-American-Rescue-Plan-Act-2021.pdf

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Resources

- **DOL MHPAEA compliance tools**

  DOL Self Compliance Tool:
  https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

  DOL MHPAEA NQTL Warning Signs Checklist:
  https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

  DOL 2020 Report to Congress: Parity Partnerships:
  https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/dol-report-to-congress-parity-partnerships-working-together.pdf

  DOL 2020 MHPAEA Enforcement Fact Sheet:
  https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2020.pdf

  DOL Compliance Assistance Materials Index:
  https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/compliance-assistance-materials-index.pdf

  Disclosure Guide: Making the Most of Your Mental Health and Substance Use Disorder Benefits:
  https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/mental-health-parity/disclosure-guide-making-the-most-of-your-mental-health-and-substance-use-disorder-benefits.pdf

Questions

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Thank you!

Please complete the survey that follows the seminar.

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