BCLP BENEFITS Q3 2020 NEWSLETTER

COVID-19 and Additional Regulatory Guidance

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OVERVIEW FROM THE EMPLOYEE BENEFITS & EXECUTIVE COMPENSATION GROUP

In this edition of our newsletter, we have summarized key third quarter guidance from the Internal Revenue Service ("IRS"), Department of Labor ("DOL"), and Pension Benefit Guaranty Corporation ("PBGC"). As we look back on the third quarter of 2020, there has been a noticeable shift at the federal level from a focus on guidance related to the COVID-19 pandemic and the Congressional response in the first half of the year to a return to executing the regulatory agendas of the federal agencies and the priorities of President Trump's administration. Despite this shift, federal agencies have continued to issue new, amended, or extended COVID-19 guidance as the circumstances of the COVID-19 pandemic continue to evolve. We have, therefore, included both COVID-19 and non-COVID-19 guidance in this newsletter and group the summaries by these categories.

If you have any questions about a topic included in this newsletter, please contact a member of our Employee Benefits & Executive Compensation Group.

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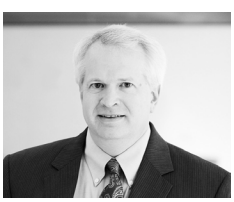

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COVID-19 GUIDANCE

SDNY Invalidates Portions of COVID-19 Paid Sick Leave DOL Regulations and DOL Responds

By Patrick Becker & Cass Hollis

On April 1, 2020, the DOL issued its initial temporary rule ("Initial Rule") related to the Families First Coronavirus Response Act ("FFCRA"). The Emergency Family and Medical Leave Expansion Act ("EFMLEA"), which amended the Family Medical Leave Act ("FMLA") to require certain paid emergency childcare leave and the Emergency Paid Sick Leave Act ("EPSLA"), which requires employers with fewer than 500 employees to provide two weeks of paid sick time for use with any of six qualifying COVID-19 related conditions were enacted as part of FFCRA. On April 14, 2020, the State of New York filed suit against the DOL challenging certain provisions of the Initial Rule (*New York v. Dept. of Labor*, 20-CV-3020 (JPO) (S.D.N.Y. Aug. 3, 2020)) and asserting that the DOL exceeded its agency authority under the statute. The Southern District of New York issued their ruling on August 3, 2020 ("N.Y. Court Ruling"). On September 11, 2020, the DOL issued a revised rule ("Revised Rule") in response to the court's ruling, and the Revised Rule became effective September 16, 2020.

1. **Court's Ruling - Work Availability Requirement:** The Initial Rule provided that an employee could only take paid leave under FFCRA if the employer had work available for the employee from which leave could be taken. Under the Initial Rule, the work availability requirement only applied to some, but not all, of the six specified reasons for which leave is permitted. The court invalidated this provision because the DOL's explanation for this requirement was "patently deficient" and the DOL provided no justification for applying the requirement to only a portion of the enumerated reasons for leave.

   DOL Response: The DOL reasserted the work availability requirement in the Revised Rule and made the requirement applicable to all of the enumerated reasons for which FFCRA leave is available. The DOL concluded that leave is an authorized absence from work, and if there is no expectation for the employee to work, the employee is not taking leave. The DOL noted that allowing an employee to take leave under FFCRA with no work availability requirement could result in a furloughed or laid-off employee who would otherwise be entitled to leave under FFCRA receiving paid leave while other employees in a similar position who did not meet one of the leave requirements would not be eligible for paid leave.

2. **Court's Ruling – Intermittent Leave:** The Initial Rule required that employees seeking to take intermittent leave from an employer where workplace infection is not a concern must obtain employer consent. The court vacated the consent requirement on the basis that it was entirely unreasoned but upheld the Initial Rule's ban on intermittent leave for certain qualifying reasons that implicate an employee's risk of viral transmission.

   DOL Response: In the Revised Rule, the DOL reasserted the employer consent requirement for an employee to take intermittent leave, stating that employer approval for intermittent leave is consistent with the FMLA requirement that leave should not unduly disrupt the employer's operations. In addition, the DOL provided that the employer-approval condition would not apply to employees who take FFCRA leave for full-day increments to care for children whose schools operate on a hybrid basis. In that case, each remote school day would be considered a separate reason for FFCRA leave rather than intermittent leave for one sustained reason.

3. **Court's Ruling – Documentation:** New York challenged the Initial Rule's requirement that employees provide documentation to employers before taking FFCRA leave. The EFMLEA requires employees to provide notice of leave as soon as practicable and where the need is foreseeable. The EPSLA requires employees to follow reasonable notice procedures. The court held that, to the extent the Initial Rule conflicts with the plain language of FFCRA with respect to documentation and notice requirements, the Initial Rule could not stand.

   DOL Response: In the Revised Rule, the DOL modified the notice provisions under the Initial Rule to provide that documentation relating to the leave does not have to be provided before the leave but should be given as soon as practicable. If the need for the leave is foreseeable, notice and documentation of the leave will be required in advance. In other circumstances where the need for leave is not foreseeable, the notice and documentation may be provided after the leave begins.

4. **Court's Ruling – Definition of Health Care Provider:** FFCRA provides that employers can exclude "health care providers" from the EFMLEA and EPSLA leave provisions and defined health care providers as individuals capable of providing health care services. In the Initial Rule, the DOL expanded the FFCRA definition to include all employees of any organization providing health care services. This expansive definition would treat "an English professor, librarian, or cafeteria manager at a university with a medical school" as health care providers who would not be eligible for FFCRA leave. The court held that the definition of health care provider in the Initial Rule was vastly overbroad and should only include those employees capable of providing healthcare services rather that hinging entirely on the identity of the employer.

   DOL Response: In response to the Court's ruling, the DOL created a new definition of health care provider in the Revised Rule that is more broad than the FMLA definition that the court championed on the basis that health care providers should include a broader group of employees in light of the COVID-19 pandemic and the need for continuity of operations for the health care system, as well as the less traditional health care services that might be required. Under the Revised Rule, the definition of health care provider includes employees who meet the definition of health care provider under the FMLA (doctors of medicine and osteopathy and others capable of providing health care services such as podiatrists, dentists, clinical psychologists, optometrists, chiropractors, nurse practitioners, midwives, clinical social workers and physician assistants among others) and employees whose duties are directly related to the provision of health care services or are so integrated with and necessary for the provision of patient care that , if not provided, patient care would be adversely impacted. The Revised Rule defines health care services as diagnostic, preventive, treatment and integrated services.

   As originally issued, the Initial Rule limited the circumstances under which paid leave could be taken under the FFCRA. After the New York court ruling and the DOL's issuance of the Revised Rule, the circumstances under which paid leave is available are somewhat expanded but employers should consider working with their counsel to ensure that their policies comply with the ever-changing landscape.

HHS Extends Public Health Emergency due to COVID-19

By Randy Scherer & Stephen Evans

On July 23, 2020, the Department of Health and Human Services ("HHS") extended its determination that there was a public health emergency due to COVID-19 for 90 days, through October 23. The public health emergency was again renewed on October 2, effective October 23. While the public health emergency remains in effect, the coverage requirements under Section 6001 of the FFCRA will remain in place. Under those requirements, group health plans and insurers offering group or individual health insurance coverage must cover, without cost-sharing, diagnostic tests and related items or services provided during an office, urgent care, or emergency room visit that result in an order for or administration of a COVID-19 diagnostic test.

Technical Update 20-2: PBGC Reverses Course on PBGC Premiums

By Serena Yee

Background

Plan sponsors of defined benefit plans must pay premiums each year to the PBGC. The premiums include a flat rate premium based on the number of plan participants and, for underfunded plans, a variable-rate premium (VRP) based on the funded position of the plan. For this purpose, the value of the plan's assets would reflect contributions made in the prior year but only to the extent received by the plan by the date the premium is filed. The last date for a timely premium filing is the 15th day of the tenth month of the plan year (i.e., October 15 for calendar year plans).

Section 3608 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act extended the deadline for plan sponsors to make any minimum required contributions that would otherwise be due during 2020 to January 1, 2021.

Reversal of Prior Guidance

In Q&As issued in July, the PBGC clarified that despite the CARES Act extension, the effective deadline for making contributions to reflect in calendar-year filings would remain October 15, 2020 (and not January 1, 2021). In other words, any contributions made between October 16, 2020, and January 1, 2021, would not reduce the plan sponsor's 2020 variable-rate premium. Consequently plan sponsors wishing to take advantage of the CARES Act delay would face a 4.5% variable-rate premium on contributions made after the standard October 15 filing due date.

However, in a reversal of the previously issued guidance, the PBGC announced in September that the date by which prior year contributions must be received by the plan to be included in valuing plan assets under the PBGC's premium rates regulation is being extended to January 1. 2021.

Under Technical Update 20-2, plan sponsors must still make their premium filings on time (by October 15, 2020 and without reflecting contributions expected to be made after the filing) and can request a refund of any excess variable rate premium by submitting an amended filing by February 1, 2021 after all delayed contributions have been made. As part of the process to obtain a refund of the original premium paid, the plan administrator must include an explanation of why the premium amount reported in the amended premium filing is less than the amount originally reported. Pursuant to the Technical Update, the plan administrator should reference the Technical Update and report the dates and amounts of the additional contributions that were not reflected in the value reported in the original filing. Once the amended filing is processed, the excess premium paid will be refunded or credited towards next year's premium.

Postponed Due Date for Reporting and Payment of Excise Taxes Relating to Minimum Required Contributions

By Randy Scherer & Stephen Evans

In September, IRS Announcement 2020-17 extended the due date for reporting and paying the 10% excise tax on unpaid minimum required contributions to defined benefit plans under Internal Revenue Code Section 4971(a)(1) and the 10% excise tax on the amount of defined benefit plan liquidity short falls under Internal Revenue Code Section 4971(f)(1). Under the CARES Act, employers received an extension on the due date to pay any minimum required contributions imposed by Internal Revenue Code Section 430(j) on single employer defined benefit plans. Such contributions would normally have been due on September 15, 2020. The CARES Act pushed the date back to January 1, 2021. In conjunction with this extension, the due date for reporting and payment of excise taxes pertaining to these minimum required contributions has been postponed to January 15, 2021. These excise taxes, as well as other excise taxes, are reported on Form 5330. The due dates for all other excise taxes reportable on Form 5330 are unaffected by Announcement 2020-17.

Guidance on Optional Payroll Tax Deferral

By Adam Braun

In Notice 2020-65, the IRS issued guidance regarding the administration of President Trump's executive order that permitted the deferral of payroll taxes through December 31, 2020. Under the Notice, employers may – but importantly, are not required to – defer withholding of the employee portion of the social security tax from all taxable payments of wages and compensation made between September 1, 2020, and December 31, 2020, so long as the total amount of such wages and compensation is less than $4,000 per biweekly pay period. If an employee chooses to defer, the employer must then withhold and pay the deferred Social Security taxes from other wages and compensation ratably between January 1, 2021, and April 30, 2021, with penalties accruing if the deferred amounts are not paid by May 1, 2021. Note that even if this deferral opportunity is elected, employers must continue to withhold and deposit income tax and other employment taxes (such as the Medicare tax) from employee wages. The executive order and the Notice left many unanswered questions, including (i) whether any deferral option must be applied to every eligible employee or can be limited to certain employees and (ii) how to handle deferrals for employees who subsequently terminate prior to paying the deferred amounts. As a result of these ambiguities, many employers have not opted into the payroll tax deferral and continue withholding based on their usual payroll practices.

GENERAL REGULATORY GUIDANCE

IRS Provides Clarifying Guidance Regarding Certain SECURE Act Provisions

By Adam Braun & Rick Arenburg

The IRS recently released additional guidance (in a helpful Q&A format) regarding several provisions of the Setting Up Every Community for Retirement Enhancement Act ("SECURE Act") that impact tax-qualified retirement plan sponsors, including the mandatory long-time/part-time employee eligibility requirement and the optional qualified birth and adoption distributions.

IRS Notice 2020-68 (the "Notice"), issued September 2, 2020, provides the following guidance:

- **Long-Time/Part-Time Employees.** The SECURE Act requires that, beginning January 1, 2024, 401(k) plan sponsors allow participation by part-time employees who provided at least 500 hours of service in three consecutive years. The Notice clarifies that, for purposes of determining whether a long-term, part-time employee has become vested in employer contributions, 401(k) plan sponsors are required to provide service credit for each 12-month period in which that employee has at least 500 hours of service, including service prior to January 1, 2021. Therefore, to the extent that 401(k) plan sponsors intend to provide employer contributions to these long-term/part-time employees (which is not required by the SECURE Act), plan sponsors need to be prepared to credit any vesting schedules for such employees' service (including service prior to January 1, 2021) and manage their records accordingly. Plan sponsors should start thinking about those recordkeeping requirements now, even though long-term/part-time participation is not required to begin until 2024.
- **Qualified Birth or Adoption Distributions.** A widely promoted provision of the SECURE Act is its new permissive early distribution option for qualified births and adoptions, under which participants in eligible retirement plans (including defined contribution plans and 457(b) plans, but excluding defined benefit plans) may withdraw up to $5,000 within one year following the birth or adoption of a new child without paying the 10% early withdrawal penalty. Participants may recontribute the distribution at a later date.

  The Notice cleared up several questions regarding this optional plan feature, specifically that:

  - Each parent may receive a qualified birth and adoption distribution of up to $5,000 for each child, including in the case of multiple births or adoptees (for example, twins or triplets), meaning that one participant or household may take multiple distributions of up to $5,000 in any given 12-month period;
  - Plan sponsors may rely on reasonable representations from a participant that he or she is eligible to receive a qualified birth or adoption distribution, unless the plan sponsor or plan administrator has actual knowledge to the contrary;
  - If an eligible retirement plan permits qualified birth or adoption distributions, it must also accept the recontribution of the distribution at a later date, provided that the participant is eligible to make a rollover contribution at the time; and
  - Eligible retirement plans are not required to withhold 20% of any qualified birth or adoption distribution.
- **Tax Credit for Small Plan Sponsors with EACA Provisions.** The SECURE Act established a new business credit, equal to $500 annually, for small employers (<100 employees who received at least $5,000 in compensation for the preceding year) that adopt an eligible automatic contribution arrangement (EACA) under a qualified employer plan. The credit applies to taxable years beginning after December 31, 2019. The Notice clarifies that eligible employers may only receive the credit in one 3-year credit period beginning when the employer first includes an EACA in any qualified plan. As a result, eligible employers that adopted EACA provisions prior to December 31, 2019 will not be able to take full advantage of this provision. In addition, this credit applies to eligible employers that commence participation in multiple employer plans with an EACA.

- **In-Service Withdrawals.** The Notice also clarified that the Bipartisan American Miners Act of 2019 ("Miners Act") provision lowering to age 591/2 the minimum age at which in-service distributions under defined benefit and money purchase plans may be taken is an optional plan provision.

The Notice confirms that any plan amendments required or permitted by the SECURE Act or the Miners Act must be adopted no later than the last day of the first plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans and certain collectively bargained plans).

Despite the delayed amendment deadline, we recommend that plan sponsors review their administrative practices for long-term/part-time employees and begin to consider next steps to comply with the SECURE Act's eligibility and vesting requirements for those employees, beginning January 1, 2024. In addition, plan sponsors should review this additional guidance when adopting the optional SECURE Act and Miners Act provisions described above.

What's in a Number, Anyway? New Requirements to Add Lifetime Income Disclosures to Benefit Statements

By Sarah Bhagwandin

On September 18, 2020, the DOL issued a "Pension Benefit Statements – Lifetime Income Illustrations" interim final rule (the "Interim Final Rule") regarding new information that must be provided on participant benefit statements. The Interim Final Rule implements Congress' latest effort, through the SECURE Act, to make disclosures from Employee Retirement Income Security Act of 1974 ("ERISA") retirement plans meaningful and useful to plan participants. Under the SECURE Act, Congress amended Section 105 of ERISA to require that benefit statements for ERISA defined contribution plans express a participant's current account balance both as a single life annuity and a qualified joint and survivor annuity income stream.

The hope is that by illustrating to participants how the account balance under a plan may convert to a life-long monthly payment, participants will better understand how prepared they are financially for retirement.

The DOL is soliciting comments on the Interim Final Rule through November 17, 2020.

The following describes the requirements of the Interim Final Rule and related practical considerations.

1. *Who will be responsible for preparing the benefit disclosures?*

   In most instances the plan recordkeeper can be expected to take responsibility for conforming a plan's benefit statements to these new rules. However, these new disclosures will likely generate a lot of questions from plan participants, and plan administrators should be prepared to answer them.

2. *Do these new disclosures create additional liability for Plan Administrators?*

   Potentially. However, if the added disclosures use the assumptions set-out in the Interim Final Rule and include information that is "substantially similar in all material respects" to the information required in the Interim Final Rule, the plan administrator is relieved from fiduciary liability for the accuracy of the projections.

It will be important, especially when these disclosures are first implemented, for plan administrators to assure that the recordkeeper's assumptions for preparing projections annuitizing account balances conform to the new rules, and that the disclosures on the benefit statements include all of the required information.

3. *When do benefit statements have to include the life-time income disclosures?*

   The required life-time income disclosures requirements will apply to participant benefit statements furnished after September 18, 2021.

4. *Does every quarterly benefit statement have to include a life-time income disclosure?*

   No. The Interim Final Rules only requires that one (1) benefit statement each year include the life-time income disclosure.

5. *What is included in the methodology for annuitizing the accounts?*

   The Interim Final Rule sets out the following five (5) assumptions for annuitizing account balances:

   a) commencement date – the date that payments will start
   b) participant's age on the commencement date
   c) participant's marital status
   d) interest rate for the applicable mortality table
   e) expected mortality of the participant and participant's spouse

6. *What forms of annuities must be included in the new benefit statement?*

   The Interim Final Rule requires that the life-time income statement express the current account balance as a single life annuity and a qualified joint and 100% survivor annuity.

7. *If a participant is unmarried, does the benefit statement still include a qualified joint and 100% survivor annuity projection?*

   Yes. The Interim Final Rule require that benefit statements for unmarried participants include a projection of the account balance paid as a qualified joint and 100% survivor annuity, calculated based on prescribed assumptions.

8. *Are the annuity calculations tailored for each participant, based on the participant's age?*

   No. For purposes of calculating the annuity projections, the plan will assume that the participant and participant's spouse is age 67 at the time of the projection.

   For example, assume a participant is age 40 and has a spouse who is age 37 when he or she receives a benefit statement for the account as of 12/31/2021. The benefit statement will include a projection of the monthly benefit payments in the form of a single life annuity and a qualified joint and 100% survivor annuity assuming the participant and spouse both are age 67 on 12/31/2021.

   In other words, the projections answer the question – if you retired today at age 67, what would your monthly benefit payment be under a single life annuity and qualified joint and 100% survivor annuity based on your current account value?

9. *What if the participant and the participant's spouse are not the same age?*

   The new life-time income disclosures will be based on the assumption that the participant and spouse are the same age.

10. *Will the projections include an assumption for inflation over time?*

    No. The projected monthly payments will not include an assumed adjustment to payments for inflation.

11. *Will the projections be based on the vested account balance?*

    No. The life-time income projections will be based on the participant's entire account balance, including any non-vested portion.

12. *What mortality assumptions will be made to calculate the projections?*

    The Interim Final Rule requires that plan administrators convert participants' account balances assuming mortality as reflected in the unisex mortality table under Internal Revenue Code Section 417(e)(3)(B) in effect for the last month of the period to which the statement relates.

13. *What interest rate will be used to calculate the projections?*

    Plan administrators must assume a rate of interest equal to the 10-year constant maturity Treasury (CMT) securities yield rate for the first business day of the last month of the period to which the benefit statement relates.

14. *Will the projections include an assumed cost for purchasing the annuity from an insurer?*

    No. The Interim Final Rule's required assumptions for converting participants' account balances into the required lifetime income streams do not include an "insurance load." A load factor refers to the extra amount that an insurance company may charge for a product given extra expenses and costs. An insurance load may include, for example, an allowance for an insurance company's profits, costs of insuring against systemic mortality risk, costs of holding cash reserves, advertising costs, the cost of anti-selection (if not accounted for in the mortality table), or other operating costs.

    Any cost associated with purchasing an annuity is not included in the annuity projections.

15. *What information is required to be included in the new disclosure?*

    The Interim Final Rule requires that eleven (11) brief statements be included in the disclosure in order for the plan administrator to be relieved from liability. The disclosure must briefly explain the following:

    - the commencement date and age assumptions
    - single life annuity
    - qualified joint and 100% survivor annuity
    - marital status assumptions
    - interest rate assumptions
    - mortality assumptions
    - monthly payment amounts
    - that actual monthly payments will depend on numerous factors and may vary substantially from the projections
    - that the monthly payment amounts are fixed amounts and not increased for inflation
    - that monthly payment amounts are based on the value of the entire account at the time the projection is calculated, regardless of the participant's vested percentage
    - the value of the account balance includes any loan balance, if applicable.

16. *Did the DOL issue a model disclosure?*

    Yes. The DOL issued a full model disclosure that includes all of the eleven (11) statements set-out above. The model is formatted as a single document, but plan administrators have total flexibility as to how to integrate the required language into benefit statements, limited only by the requirement that the disclosure be readable.

Michigan Auto Insurance Law Affects Self-Insured Health Plans

By Patrick Becker

The State of Michigan enacted a law, which took effect on July 1, that permits car owners to either (1) opt out of purchasing personal injury protection ("PIP") medical coverage if he or she and all family members residing in the same home have qualified health coverage ("QHC"), or (2) select a $250,000 PIP medical limit with an exclusion for PIP medical coverage for the applicant and any family members with QHC. QHC is coverage under Medicare or an accident/health policy with a deductible of $6,000 or less per individual and no coverage limits for injuries caused by car accidents. A $50,000 PIP limit is available where the applicant is enrolled in Medicaid and family members have QHC or PIP medical coverage.

Previously, the Michigan Department of Financial and Insurance Services provided guidance stating that a health plan with even one annual deductible (such as an out-of-network deductible) exceeding $6,000 would not qualify as QHC. Restated guidance (Bulletin 2020-33-INS) issued July 28, 2020 clarifies that QHC includes a plan with any annual deductible that does not exceed $6,000 per individual and doesn't exclude or limit medical coverage for injuries related to auto accidents. The guidance also indicated that a group health plan with an individual deductible offset in any manner (such as funds contributed to HRA) so as not to exceed $6,000 may also qualify as QHC. This clarification expands the number of plans that may constitute QHC.

What does this mean for employers?

Employers whose group health plans have coordination of benefits language with automobile insurance could face greater exposure with respect to claims in Michigan. The existing language of those group health plans may not help if the employer health plan otherwise meets the QHC definition, and the employer plan could end up being the sole source of medical coverage for these injuries.

In addition, employees who are Michigan drivers may request documentation as to whether the employer plan is QHC (both at the initial issuance of a policy and upon renewal). The documentation should set forth names and dates of birth of all persons covered under the QHC, and a statement as to whether the coverage constitutes QHC or that the plan does not exclude coverage for motor vehicle accidents and has an annual deductible of $6,000 or less per individual. Michigan has indicated that simply communicating a group health plan's coordination of benefit provisions does not constitute sufficient documentation as to whether the employer plan is QHC.

Employers who sponsor self-insured plans covering employees in Michigan should consider whether cost adjustments or an amendment to the plan's coordination of benefits provisions may be necessary.

IRS Announces Increased Determination Letter User Fees

By Patrick Becker

In Announcement 2020-14, the IRS issued new user fees to take effective January 4, 2021 as described in IRS Announcement 2020-14. Of particular note, the application for a Determination Letter (Form 5300) increases to $2,700 from $2,500 and the application for a Determination Letter for Terminating Plan (Form 5310) increases to $3,500 from $3,000. Employers considering filing an application for a determination letter in the near future may wish to do so before the fee increases.

President Trump Signs Executive Orders Pertaining to Drug Pricing

By Randy Scherer

In July, President Trump signed a series of four (4) executive orders relating to pricing of prescription drugs. These executive orders may have limited impact on employer-sponsored group health plans given their focus on Medicare and state-based drug importation programs, but there could be ripple effect as these executive orders are implemented. The executive orders are summarized in the following:

- The first order requires Federally Qualified Health Centers to pass negotiated discounts they receive on insulin and epinephrine through Medicare's Drug Discount Program on to patients who do not have health insurance or who have high cost sharing for those drugs.
- The second order requires HHS to facilitate the granting of waivers of the prohibition on importation of prescription drugs from outside the U.S. to individuals for FDA-approved medicines. The order also requires HHS to prioritize rulemaking to allow for the importation of certain drugs from Canada by states and pharmacies. HHS published a final rule on October 1, 2020, to permit States, Indian Tribes, and certain pharmacies and wholesale distributions to sponsor programs to import eligible prescription drugs (generally, those which could be sold legally in either Canada or the United states with appropriate labeling).
- The third order would establish an international pricing index that would set the price Medicare pays for certain costly medications it covers to the lowest price in other economically advantaged countries. Although this order was announced in July, the "most-favored nations" executive order was not published publicly until September.
- The fourth order would ban certain drug rebates used by health plan sponsors, pharmacies, or pharmacy benefit managers in operating the Medicare Part D program and pass those rebates on to patients. The order requires the Secretary of HHS to confirm that Medicare premiums, federal spending, and patients' overall out-of-pocket costs will not increase due to the rebate ban.

DOL Issues Proposed Rule on Pooled Plan Provider Registration

By Randy Scherer

The SECURE Act amended ERISA and the Internal Revenue Code to establish a new type of multiple employer plan: the pooled employer plan ("PEP"). A PEP, unlike a traditional multiple employer plan, allows unrelated employers of all sizes to participate, without the need for commonality among the employers. The goal is to give small employers more opportunities to provide retirement plan options to their employees, while lowering the administrative burdens and costs associated with sponsoring their own retirement plans.

The SECURE Act requires PEPs to be administered by a pooled plan provider. Although the SECURE Act does not outline who may operate as a pooled plan provider, financial services companies, including insurance companies, banks, and record keepers, are most likely to sponsor PEPs. The SECURE Act allows pooled plan providers to begin operating PEPs as early as January 1, 2021, after registering with the Secretary of Labor and the Secretary of the Treasury.

On September 1, 2020, the DOL issued a proposed rule (the "Proposed Rule") that would establish a simple registration process for businesses who want to sponsor PEPs. The registration would also serve as a source of information for companies who are considering joining a PEP. Under the Proposed Rule, there would be three types of registration filings for pooled plan providers:

1. **Initial Registration:** A business would be required to file an initial registration form using the new Form PR no sooner than 90 days before and no later than 30 days before beginning operations as a pooled plan provider. Form PR would include identifying information about the pooled plan provider, basic information on the services provided, the roles of any affiliates expected to provide services, identifying information for the pooled plan provider's compliance officer, the name and address of the agent for service of process, and information on the existence of any civil, criminal or administrative actions relevant to the pooled plan provider's operation of employee benefit plans. Form PR would utilize the EFAST 2 electronic filing system.
2. **Supplemental Filings:** The occurrence of certain reportable events would require supplemental filings. Supplemental filings would be required for each new PEP before it begins operations, to address any changes in information from the initial registration filing, and when certain key events occur (e.g., a change in the pooled plan provider's corporate structure or the initiation of bankruptcy proceedings).
3. **Final Filing:** If a business terminates its last PEP and it ceases operations as a pooled plan provider, it would file a final Form 5500 and a final Form PR so indicating.

Proposed Proxy Voting Limits for Plan Fiduciaries

By Adam Braun

In September 2020, the DOL published proposed rules regarding the obligations of plan fiduciaries to vote proxies based on the relevant plan's investment holdings, in part to clarify that plan fiduciaries are not required to vote all proxies or spend plan assets to vote on issues that do not have any economic impact on the plan, provided that such determinations to vote or not vote are made prudently and solely in the interests of participants and beneficiaries.

Under the proposed rules, plan fiduciaries (i) are required to participate in any proxy vote when the fiduciary prudently determines that the matter being voted on would have an economic impact on the plan, and, inversely, (ii) are prohibited from participating in any proxy vote unless the fiduciary prudently determines that the matter has an economic impact on the plan. In deciding whether a proxy vote has an economic impact on the plan, plan fiduciaries would be permitted to rely on certain "permitted practices" set forth in the proposed rules, which include policies that require: (a) voting in accordance with recommendations of the issuer's management (subject to certain restrictions), (b) voting only on specific proposals that are substantially related to the issuer's business activities or will significantly impact the value of the plan's investment (e.g., mergers and acquisitions), and/or (c) refraining from voting on a proposal unless a plan's investment in the issuer exceeds a specific quantitative threshold. Such polices or guidelines must be reviewed at least biannually and be made available to plan participants. Comments to the proposed rules were due on October 5, 2020. If the proposed rules are adopted in their current form, plan fiduciaries will likely have to re-evaluate their procedures for voting proxies and may need to adopt or amend proxy voting guidelines consistent with the guidance in the proposed rules.

IRS Releases Updated Safe Harbor Rollover Notices

By Stephen Evans

The IRS released Notice 2020-62, which provides safe harbor explanations that may be used by plan administrators to comply with the eligible rollover distribution notice requirements under Internal Revenue Code Section 402(f). The new safe harbor explanations update the explanations that were provided under Notice 2018-74. The revised notices include clarification that distributions of certain premiums for health and accident insurance are not eligible for rollover and revisions to reflect changes in law made by the SECURE Act, including the exception to the 10% early withdrawal penalty for qualified birth or adoption distributions and the increase in the age to commence required minimum distributions from age 70½ to age 72 (for employees born after June 30, 1949). Notice 2020-62 also clarifies that Section 402(f) notices are not required for coronavirus-related distributions under the CARES Act.

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