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In this Issue:

Agencies Issue Guidance on Group Health Plan "Gag Clause" Ban

Group health plans and health insurance issuers must submit their first annual attestations of compliance with

new rules banning certain "gag clauses" in contracts with providers and others by December 31, 2023. The initial attestation will cover the period from December 27, 2020 – when the gag clause prohibition was enacted and took effect – through the date of attestation.

The new guidance on the Gag Clause Prohibition Compliance Attestation and other aspects of the "gag clause" ban was included in a set of Frequently Asked Questions ("FAQs") issued by the Departments of Health and Human Services, Labor, and Treasury ("Agencies") on February 23, 2023.

Background

The Consolidated Appropriations Act, 2021 ("CAA 2021") amended the Code, ERISA, and the Public Health Service Act to prohibit group health plans and group health insurance issuers from entering into agreements with health care providers, a network of providers, third-party administrators ("TPA"), or other service providers offering access to a network of providers that include certain "gag clauses." For this purpose, a "gag clause" refers to any direct or indirect:

- restrictions on the disclosure of provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;

- restrictions on electronic access to de-identified claims and encounter information or data for each participant, beneficiary, or enrollee upon request and consistent with HIPAA and other privacy rules; and

- restrictions on sharing any information or data described above, or directing that such information or data be shared, with a business associate pursuant to the HIPAA privacy rule.

Additionally, the rules require group health plans and issuers to submit an annual attestation of compliance – the Gag Clause Prohibition Compliance Attestation – to the Agencies. Previous guidance indicated that the Agencies planned to begin accepting attestations in 2022, but these FAQs establish December 31, 2023 as the deadline for submitting the initial attestations.

Completing and Filing the Attestation

As noted, the FAQs confirm the first Gag Clause Prohibition Compliance Attestation is due by December 31, 2023. This first attestation will cover the period from December 27, 2020 through the date of attestation. Subsequent attestations will be due by December 31 of each year thereafter.

The attestation must be submitted by group health insurance issuers, and by fully-insured and self-insured group health plans. This includes most ERISA plans, non-federal governmental plans, and Church plans subject to the Code. Group health plans that are "grandfathered" for purposes of the Affordable Care Act are subject to the prohibition on gag clauses, and also must file the annual attestation.

The FAQs clarify that HRAs and other account-based group health plans, as well as plans or issuers providing only "excepted benefits," are not subject to the attestation requirement. The FAQs do not specifically address retiree-only plans (i.e., plans with fewer than 2 participants who are active employees), but

as a statutory matter those plans should be exempt for the same reason as plans providing only "excepted benefits."

Self-insured and partially self-insured group health plans may enter into an agreement to file the Gag Clause Prohibition Compliance Attestation on the plan's behalf. However, the plan will continue to be responsible for ensuring the appropriate attestation is timely filed.

In the case of fully-insured plans, the FAQs provide both the group health insurance issuer and the group health plan must file a Gag Clause Prohibition Compliance Attestation. However, when the issuer submits the Gag Clause Prohibition Compliance Attestation on the plan's behalf, the Agencies will consider both the plan and issuer to have satisfied the attestation requirement.

Many group health insurance issuers also provide TPA-only services to self-insured plans. The FAQs clarify that group health issuers can submit a single Gag Clause Prohibition Compliance Attestation on behalf of itself, its fully-insured group health plans, and its self-insured plan clients.

A plan or issuer may authorize "any appropriate individual" within the organization to attest on behalf of the plan or issuer.

The Agencies have established a website to receive the Gag Clause Prohibition Compliance Attestation. Instructions and other information, including a link to the page for submitting the Gag Clause Prohibition Compliance Attestation, is available at: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance.

DOL Releases Final Revisions to Form 5500

The final revisions implement long-awaited Form 5500 changes, such as adding a new Schedule DCG for defined contribution groups, adding a new Schedule MEP for multiple employer plan reporting, and making changes to participant count methodology for purposes of certain audits.

Background

In September 2021, the Department of Labor ("DOL"), the Internal Revenue Service ("IRS"), and the Pension Benefit Guaranty Corporation ("PBGC") (the "Agencies") released proposed updates to the Form 5500, which is used to report information on the qualification of a plan, its financial condition, investments and the operations of the plan. The proposal included changes to the Form 5500 that were enacted as part of the SECURE Act of 2019 and also included a number of additional revisions. The Agencies released a limited number of final revisions in December 2021 and May 2022, which generally implemented revisions that were applicable beginning with the 2021 or 2022 plan year forms. (See RPI 2022-12 for more information on the final revisions released in May 2022.)

Form 5500 Revisions

On February 24, 2023, the Agencies released a third set of final form revisions to the Form 5500. Some key highlights of the final revisions include:

- Changes for Defined Contribution Groups. Under the SECURE Act of 2019, DOL and IRS must allow so-called defined contribution groups ("DCGs") to file a single, consolidated Form 5500, as long as certain conditions are met. To be considered a DCG, a group of defined contribution plans must share certain similarities, such as the same trustee, same administrator, plan years beginning on the same date, and the same investment options. The final revisions implement this requirement by adding a new "Schedule DCG" to the Form 5500, which allows reporting of individual plan-level information, including financial information, plan characteristics, and compliance questions. Notably, with respect to the existing requirement that certain plans include an audit report with their Form 5500, the final form revisions generally require *separate* audits of each individual plan. The final revisions do not incorporate all aspects of the original proposed revisions. For instance, the final revisions eliminate a rule in the proposed revisions that would have required plans participating in a DCG to use a "single trust" in addition to having the same trustee.
- New Schedule MEP. Currently, multiple employer plans ("MEPs") report information regarding the employers participating in the MEP by including a non-standardized attachment with their Form 5500. The final form revisions create a new Schedule MEP, which will be used for MEPs to report the information they are currently reporting on the non-standardized attachment. The proposal had asked commenters to weigh on whether more "specifically tailored questions" should be added to the Schedule MEP, such as those to report fee and expense information on MEPs. The final revisions do not add any additional questions.
- Changes to Participant Count Methodology. The final revisions also incorporate changes to the method DC plans must use to count participants for purposes of determining whether the plan is subject to the Form 5500's current audit requirement for large plans. Currently, plan size is determined based on the total number of participants at the beginning of the plan year, including those who are eligible to have contributions made under a 401(k) plan (even if they have not elected to participate and have no account balance). Under the new revisions, plans generally need only count the number of participants that actually have account balances as of the beginning of the plan year.

Some revisions that were originally proposed in September 2021 were not included in any of the three final revisions. The Agencies note that these changes have been deferred for further development as part of a separate Form 5500 project included on DOL's future regulatory agenda.

IRS Proposes Updated Rules on Forfeitures in Retirement Plans

The proposed rule would formalize the informal position that the IRS has taken regarding the use of forfeitures. For defined contribution ("DC") plans, forfeitures would

have to be used within 12 months of the end of the plan year in which the forfeiture incurred to pay administrative expenses, reduce employer contributions, or increase benefits.

Background

If a participant in a DC or defined benefit ("DB") plan terminates their employment without meeting the plan's vesting requirements, they forfeit those benefits. A participant could also forfeit benefits if the plan cannot locate them, but benefits may be reinstated if a claim is later made by the participant or a beneficiary.

Under the Internal Revenue Code, a pension plan must provide that forfeitures will not be applied to increase the benefits any employee would otherwise receive under the plan. In 1963, the IRS released a corresponding regulation to this rule, which provided that a pension plan may anticipate the effect of forfeitures in determining costs under the plan. This regulation did not address DC plans and has not been updated since its original release. In 2010, the IRS included an article in its Employee Plans Newsletter which stated that a DC plan may not place forfeited amounts in a plan suspense account and allow those funds to accumulate over several years. In the article, the IRS noted that it expected forfeitures to be used fairly quickly to pay expenses or reduce employer contributions, but no later than the end of the next plan year. The IRS never released any formal guidance taking the position it detailed in the newsletter.

Proposed Rule

On February 27, 2023, the IRS released a proposed rule to update its forfeiture regulation and essentially formalize the informal position it took in the newsletter with respect to forfeitures. In the case of a DB plan, the proposed regulation would clarify that a plan would be required to expressly provide that forfeitures may not be applied to increase the benefits any employee would otherwise receive under the plan at any time prior to the termination of the plan or the complete discontinuance of employer contributions thereunder. A plan could continue to anticipate forfeitures in determining its funding requirements.

In the case of a DC plan, the plan would be required to expressly provide that forfeitures will be used for one or more of the following purposes: (1) to pay plan administrative expenses, (2) to reduce employer contributions under the plan, or (3) to increase benefits in other participants' accounts in accordance with plan terms. The plan must also expressly provide that forfeitures will be used no later than 12 months following the close of the plan year in which the forfeitures were incurred under plan terms. The regulation is proposed to apply for plan years beginning on or after January 1, 2024 but includes a transition rule for certain forfeitures.

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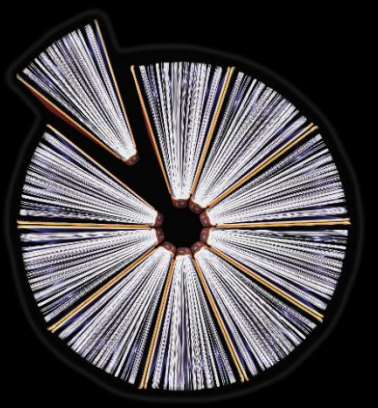

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