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Insider

Democrats gain Senate majority as President Biden continues transition

By Ann Marie Breheny, Maureen Gammon and Steve Seelig

The January 5 run-off elections in Georgia created a 50 – 50 tie in the Senate, which gave Democrats the majority after Vice President Kamala Harris was sworn in and now has the authority to cast tie-breaking votes. Democrats also hold a majority in the House of Representatives. With majorities in both chambers, the priorities and agenda for the 117th Congress will take shape over the next few weeks, and more information about the early priorities of the new Biden administration will continue to emerge.

Following is an overview of the potential impacts to health care, retirement and other benefit-related legislation as of the time of this writing.

Senate results and outlook

The outlook for the 2021 – 2022 congressional term depended significantly on the results of the January 5 run-off elections in Georgia. Now that Democrats hold majorities in both the House and Senate, there will be a smoother path for President Biden's political appointees and for legislative enactment of some of his policy proposals. A 51-vote majority will allow Democrats to use the budget reconciliation process and the Congressional Review Act (CRA) to achieve some legislative goals. The path is not entirely clear, however. Obstacles remain that could impede action on some issues.

Senate Democrats are expected to use the budget reconciliation process to move some budget and tax legislation. Budget reconciliation procedures allow the Senate to approve legislation with 51 votes instead of the 60 votes usually required under current Senate rules, but the rules limit provisions that may be included in budget reconciliation legislation.

Tax changes generally qualify for budget reconciliation, which could allow action on important health and retirement provisions. For example, budget reconciliation could be a possible legislative vehicle for expanded Affordable Care Act (ACA) premium tax credits, pension funding stabilization, retirement savings incentives, student loan repayment assistance and other provisions. Budget reconciliation cannot be used for all legislative priorities, however, because reconciliation rules limit the provisions that may be considered. Provisions that do not affect revenues or budget outlays may not be considered under budget reconciliation. Prohibited provisions also include, among others, those that increase future budget deficits, changes to Social Security and those for which the revenue effects are incidental to the underlying policy.

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With a Democratic majority in the Senate, Congress may use the CRA to disapprove some recent rules issued by the Trump administration. The CRA allows Congress to overturn regulations under special fast-track legislative procedures. The current Congress may use the CRA to overturn regulations that were issued during approximately the last 60 legislative session days of 2020.

Regular legislative procedures will be available for policies that do not qualify for budget reconciliation or the CRA. Under current Senate rules, legislation generally requires a 60-vote majority to end debate and take a final vote for approval. Thus, a one-vote Democratic margin in the Senate will likely limit the policies enacted through regular legislative procedures, except for legislation that attracts strong bipartisan support and for must-pass legislation, such as appropriations bills.

Democrats will now chair the Senate committees in addition to those they already chair in the House. Senator Ron Wyden (D-OR) is expected to chair the Senate Finance Committee. Active in retirement and health care discussions, he has sponsored or cosponsored important retirement, health and compensation legislation, including the Retirement Enhancement and Savings Act, Retirement Parity for Student Loans Act and Prescription Drug Pricing Reduction Act, among others. Senator Patty Murray (D-WA) is expected to chair the Health, Education, Labor and Pensions (HELP) Committee. She has also been active in health care and retirement policy as well as paid leave, childcare and fair pay legislation. Both committees are expected to discuss retirement, health care, compensation and workforce policies during the 2021 – 2022 legislative term.

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***Insider* authors**

Precious Abraham
Mercedes Aguirre
Ann Marie Breheny
Cindy Brockhausen
Gary Chase
Stephen Douglas
Maureen Gammon
Rich Gisonny
Anu Gogna
Russ Hall
William Kalten
Benjamin Lupin
Brendan McFarland
Steve Nyce
Laura Rickey
Kathleen Rosenow
Steven Seelig
Verónica Vassallo
Lindsay Wiggins

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For permissions and reprint information, please email Joseph Cannizzo at joseph.cannizzo@willistowerswatson.com.

More information can be found on the website: www.willistowerswatson.com.

Publication company
Willis Towers Watson
Research and Innovation Center
800 N. Glebe Road
Arlington, VA 22203
T +1 703 258 7635

[The Senate Finance and HELP committees] are expected to discuss retirement, health care, compensation and workforce policies during the 2021 – 2022 legislative term.

COVID-19 will likely be a top early priority for the 2021 legislative session. After the Consolidated Appropriations Act, 2021 was enacted in December 2020, Democratic leaders in Congress said they would seek additional relief and economic stimulus. President Biden has announced the American Rescue Plan, a COVID-19 stimulus plan for Congress to consider. The legislation is expected to include an additional direct payment of $1,400 to most Americans (in addition to the $600 authorized in December) and increasing unemployment assistance by $400 per week, $350 billion assistance for state and local governments, $170 billion for primary and higher education, $50 billion toward COVID-19 testing and vaccination, and increasing to $3,000 per child ($3,600 for a child under age 6) the childcare credit. The American Rescue Plan also proposes to subsidize COBRA continuation coverage and reinstate and expand COVID-19 paid leave mandates that lapsed at the end of 2020. The legislation seems likely to move to legislative debate soon after the inauguration.

Biden transition update

Biden has announced important cabinet nominees and engaged in other transition activities.

Biden's transition team announced that they will impose a regulatory freeze at noon on January 20. This freeze, which has been standard procedure during recent transitions, generally provides that new regulations cannot be published until they are reviewed by the new administration. In addition, it often delays the effective date of regulations that were published but did not take effect before the inauguration. Biden's spokesperson said the freeze would apply to guidance documents as well as regulations. Specific details about the freeze will be available when the freeze is formally issued on January 20. The transition team also indicated Biden would rescind some executive orders issued by President Trump. Biden had previously announced that he planned to issue new executive orders during the first days of his administration.

Biden has also announced important cabinet nominations, including Janet Yellen to serve as Treasury Secretary, former Rep. Xavier Becerra to serve as Secretary of Health and Human Services, and former Boston Mayor Marty Walsh to serve as Secretary of Labor. Cabinet nominees, chairs of independent agencies — such as Gary Gensler nominated to head the Securities and Exchange Commission — and scores of additional executive and judicial nominees must be approved by the Senate. A Democratic majority in the Senate will likely smooth the path for most nominees, but the process of approving nominees for a new administration typically consumes significant Senate committee and floor time during the early weeks of a new administration.

For comments or questions, contact Ann Marie Breheny at +1 703 258 7420, ann.marie.breheny@willistowerswatson.com; Maureen Gammon at +1 610 254 7476, maureen.gammon@willistowerswatson.com; or Steve Seelig at +1 703 258 7623, steven.seelig@willistowerswatson.com.

President Trump signs government funding and COVID-19 stimulus bill

By Ann Marie Breheny, Stephen Douglas, Anu Gogna and Ben Lupin

On December 21, 2020, Congress approved the Consolidated Appropriations Act, 2021, and on December 27, President Trump signed the act into law. In addition to funding the federal government through September 30, 2021, the $2.3 trillion government funding and economic stimulus package includes provisions affecting employer-provided health, retirement and other benefit plans. The act also includes economic stimulus payments, temporary unemployment enhancements, extension and expansion of the Paycheck Protection Program, extension and improvement of the employee retention tax credit, and other provisions.

Effective dates and implementation of the provisions vary. Some extend existing law, while others will require plan sponsors to take action to ensure compliance.

Some [provisions] extend existing law, while others will require plan sponsors to take action to ensure compliance.

Health care provisions

The Consolidated Appropriations Act prohibits surprise medical billing and includes consumer protection provisions. It also includes new disclosure requirements for health plan sponsors, a mental health parity analysis requirement, temporary flexibility for health and dependent care flexible spending accounts (FSAs), and other provisions.

- **Surprise medical billing:**
  - The act generally prohibits surprise medical billing 1) for emergency care, 2) in other circumstances when a patient does not select the medical provider or facility, and 3) when out-of-network providers and facilities do not provide notice and obtain informed consent. Surprise billing for air ambulance services is also prohibited.
  - In cases where surprise billing is prohibited, patients will pay only the cost-sharing amounts they would pay for in-network services, which will count toward the patient's in-network deductible and out-of-pocket limit. Out-of-network providers and facilities will be prohibited from balance billing the participant.
  - Payments to out-of-network providers generally will be negotiated between the plan and provider during a 30-day open negotiation period. If the parties are unable to reach agreement, payment will be determined through an independent dispute resolution process.
  - Ground ambulance services are not covered by the provisions; a federal advisory committee will be appointed to review issues relating to balance billing for those services.
  - The surprise billing provisions take effect for plan years that begin on or after January 1, 2022.

- **Health care transparency:**
  - *Deductibles and out-of-pocket limits on insurance cards:* Physical and electronic cards issued by health plans must disclose in-network and out-of-network deductibles and out-of-pocket limits. They must also list a phone number or website where patients can obtain information about in-network providers.
  - *Advance explanation of benefits (EOB):* Health plans must provide patients with an advance EOB, which describes the network status of providers and the individual's expected cost sharing. These provisions are similar, though not identical, to requirements in the recently issued transparency in coverage regulation.[1]
  - *Price comparison tool:* Health plans must provide a price comparison tool that allows enrolled individuals to compare cost-sharing amounts they would pay for care from participating providers. Like the advance EOB, the provision is similar to requirements in the recent transparency in coverage regulation.
  - *Accuracy of provider directories:* The act establishes requirements for ensuring that provider directories are accurate and up to date. Patients will be protected from out-of-network costs if the directory inaccurately indicates that a provider participates in the plan's network.
  - *Reporting of benefits and drug costs:* Health plans must provide annual disclosure regarding certain drug cost and plan information. The disclosure must include the number of enrollees in the plan, each state in which the plan operates, the 50 most costly prescribed drugs by total annual spending, the 50 drugs with the greatest increase in plan spending, total spending of health care services by type of cost and other information.
  - *Ban on gag clauses relating to cost and quality:* The act bans clauses that prohibit the disclosure of price or quality information.
  - *Disclosure of broker and consultant compensation:* The act requires disclosure of compensation for brokers and consultants to employer-sponsored health plans and for coverage sold in the individual insurance market.
- **Mental health parity analysis:** Health plans must conduct a comparative analysis of the design and application of nonquantitative treatment limitations (NQTLs) that apply to their medical/surgical benefits and their mental health/substance use disorder benefits. They must also make certain information available upon request, including the comparative analysis, specific plan language or plan terms relating to NQTLs, the services to which NQTLs apply, evidentiary standards and other information.
- **Requirement to issue guidance for ACA provider nondiscrimination provision:** The Affordable Care Act (ACA) prohibits health plans from discriminating against providers acting within the scope of their license or certification. Although the Departments of Labor, Treasury, and Health and Human Services have not issued guidance on this provision because they determined that it was self-implementing, they are now required to do so under the Consolidated Appropriations Act.
- **Health and dependent care FSAs:** The Consolidated Appropriations Act makes temporary changes to provide flexibility for health and dependent care FSAs in 2020 and 2021. More specifically, the act would provide as follows:
  - Amounts that are unused in 2020 may carry over to 2021, and amounts that are unused in 2021 may carry over into 2022.
  - Health and dependent care FSA grace periods for plan years ending in 2020 or 2021 may extend until 12 months after the end of the plan year.
  - Participants who cease participation in the plan during 2020 and/or 2021 (terminated participants) may continue to be reimbursed if they have unused amounts in their health and/or dependent care FSA.
  - Plan participants will be permitted to make prospective changes to their health and/or dependent care FSAs during 2021.
  - Dependent care FSAs may reimburse expenses for dependents who reach age 14 during 2020.

The Consolidated Appropriations Act makes temporary changes to provide flexibility for health and dependent care FSAs in 2020 and 2021.

Retirement provisions

The Consolidated Appropriations Act includes several retirement provisions but does not include the defined benefit plan funding stabilization provisions that were approved by the House earlier in 2020. The retirement provisions:

[1] See "**Q&A: Final rule on health care transparency**," *Insider*, November 2020.

- **Expand the availability of coronavirus-related distributions to money purchase pension plans:** The act allows in-service coronavirus-related distributions from money purchase pension plans and is retroactive to the date of the passage of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (i.e., March 27, 2020); however, because coronavirus-related distributions under the CARES Act must be made before December 31, 2020, this provision may be of limited value.
- **Provide a temporary rule preventing partial plan termination:** The act includes a provision that allows plan sponsors to factor in rehires made before March 31, 2021, when determining whether a retirement plan has incurred a partial termination that would require affected participants to be fully vested. More specifically, a plan will not be treated as having a partial termination for any plan year that includes the period beginning March 13, 2020, and ending March 31, 2021, provided that the number of active participants covered by the plan on March 31, 2021, is at least 80% of the number of active participants on March 13, 2020.
- **Allow plan sponsors to terminate section 420 transfers:** The act allows employers that have elected a "qualified future transfer" under Internal Revenue Code section 420 of excess defined benefit plan assets to cover future retiree health/life insurance costs to end any existing "transfer period" and restore the unused funds to the plan provided such election is made by December 31, 2021, and several additional conditions are met.
- **Expand COVID-19-related relief to other disaster situations:** Under the act, retirement plan participants impacted by presidentially declared disasters (other than COVID-19) can take advantage of special retirement plan distribution and loan provisions (similar to those included in the CARES Act) for disasters declared from January 1, 2020, through February 25, 2021. This provision only applies to distributions and loans made through June 25, 2021 (180 days after enactment of the Consolidated Appropriations Act).

Extension of expiring tax provisions

The Consolidated Appropriations Act extends a number of expired or expiring tax provisions.

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- **Student loan repayment assistance:** The provision that allows employer-provided student loan repayment assistance under Internal Revenue Code section 127 is extended through December 31, 2025. The provision, which was enacted by the CARES Act, had been scheduled to expire on December 31, 2020.
- **Health Coverage Tax Credit (HCTC):** The HCTC, which applies for certain Trade Adjustment Assistance and Pension Benefit Guaranty Corporation recipients, is extended until December 31, 2021.
- **Medical expense deduction:** The 7.5% threshold for deducting qualified medical expenses is permanently extended.
- **Business meals:** The full deduction for business meals is restored for 2021 and 2022.
- **Paid leave:**
  - *Emergency paid sick leave and paid emergency leave under the FMLA:* The Families First Coronavirus Response Act (FFCRA) requires employers with up to 500 employees and state and local government employers to offer paid sick leave and paid leave under the Family and Medical Leave Act (FMLA) for specified COVID-19-related circumstances.[2] Employers with up to 500 employees are eligible for payroll tax credits to cover the cost of the paid leave. The paid leave requirements expire on December 31, 2020. The Consolidated Appropriations Act will extend the payroll tax credits until March 31, 2021, for covered employers that continue to offer the paid leave benefits provided in the FFCRA.
  - *Employer tax credit for paid FMLA:* The Tax Cuts and Jobs Act established a tax credit for employers that offer qualifying paid family and medical leave to their employees.[3] This credit is available regardless of employer size and is not restricted to the COVID-19 conditions established for emergency FMLA in the FFCRA. This employer tax credit is now extended through December 31, 2025.

[2] See "**Mandatory coverage of COVID-19 testing and small employer paid leave signed into law**," *Insider*, March 2020.

[3] See "**IRS issues guidance on tax credit for paid family and medical leave**," *Insider*, October 2018.

Going forward

Health plan sponsors should work with plan administrators and vendors to prepare for implementation of the surprise medical billing, transparency and mental health parity, and FSA provisions. Application and implications of the retirement, tax and other provisions in the Consolidated Appropriations Act will vary.

For comments or questions,
Ann Marie Breheny at +1 703 258 7420,
ann.marie.breheny@willistowerswatson.com;
Stephen Douglas at +1 203 326 6315,
stephen.douglas@willistowerswatson.com;
Anu Gogna at +1 973 290 2599,
anu.gogna@willistowerswatson.com; or
Ben Lupin at +1 215 316 8311,
benjamin.lupin@willistowerswatson.com.

2020 year-end COVID-19 stimulus law: Health and benefit implications

By Ann Marie Breheny, Anu Gogna and Ben Lupin

On December 27, 2020, President Trump signed into law the **Consolidated Appropriations Act, 2021**. The law makes important changes for employer-sponsored group health plans and other benefit programs and also includes extensive changes for unemployment and business loans in response to the COVID-19 pandemic. In general, the law 1) allows carryovers and other changes to health and dependent care flexible spending accounts (FSAs) in 2020 and 2021, 2) ends surprise medical billing, 3) includes transparency and reporting obligations for employer-sponsored group health plans, and 4) extends for five years the tax preferences for employer student loan repayment assistance and paid family and medical leave.

The law's health and benefit-related provisions are discussed in detail below, along with the potential impact on employers.

Group health plan provisions

Flexibility for health and dependent care FSAs

The Consolidated Appropriations Act allows flexibility for unused amounts in health and dependent care FSAs for 2020 and 2021, when many participants may not have the opportunity to incur expected childcare and medical care expenses because of COVID-19 circumstances. These changes are designed to help participants retain unused balances they would normally lose at the end of the tax year due to the "use it or lose it" rules in the law.

The law allows the following:

- Amounts that are unused in 2020 may be carried over to 2021; amounts that are unused in 2021 may be carried over to 2022.

The law makes important changes for employer-sponsored group health plans and other benefit programs.

- Health and dependent care FSA grace periods for plan years ending in 2020 and/or 2021 may be extended until 12 months after the end of the plan year.
- Plan participants who stop participating in the plan during 2020 and/or 2021 *(terminated participants)* may continue to be reimbursed if they have unused amounts in their health and/or dependent care FSAs.
- Plan participants may make prospective changes to their health and/or dependent care FSAs during 2021 (regardless of change in status).
- Expenses under a dependent care FSA may be reimbursed for dependents who aged out during the COVID-19 pandemic.

All of these changes are *optional*. Employers that wish to make these changes must adopt plan amendments. The law extends the deadline for making such amendments, to the end of the calendar year beginning after the end of the plan year in which the amendment is effective (so an amendment for any 2021 changes must be made by December 31, 2022). Amendments can be adopted retroactively to when the changes were implemented, provided the FSA is operated accordingly. Plan sponsors that elect to adopt the carryover or extended grace period rules should notify participants of the changes as soon as possible.

Implementing guidance for these provisions will be needed. For example, the law's language seems to indicate that the annual limit on FSA salary reductions would not be affected by the amounts that may be carried over; however, the IRS will need to confirm this and other applicable rules, such as a plan not being able to adopt both a carryover and grace period. Further, the IRS will likely need to address the impact of the carryover on nondiscrimination testing applicable to FSAs. Plan sponsors adopting the carryover rule or expanded grace period should expect fewer experience gains to offset experience losses.

No Surprises Act

The Consolidated Appropriations Act includes provisions aimed at ending surprise billing, enacted as the No Surprises Act.

Ending surprise medical billing

Effective for plan years beginning on or after January 1, 2022, group health plan participants will be protected from balance bills when they: 1) seek emergency care, 2) are transported by an air ambulance, or 3) receive non-emergency care at an in-network hospital but are treated by an out-of-network physician or laboratory without having provided their informed consent.

Instead, participants will pay only the deductibles and copayments that they would otherwise pay for in-network care under the terms of their group health plans. The amounts paid would count toward the patient's in-network deductible and out-of-pocket limit. Out-of-network providers and facilities would be prohibited from balance billing the participant. Note that these protections do not extend to ground ambulance services.

Self-insured and insured group health plans will be required to reimburse out-of-network providers and facilities in the situations where balance billing is prohibited; however, the law does not specify the amounts that must be paid. Under the law, health plans and providers generally would have 30 days to negotiate payment. If they do not reach an agreement during the 30-day period, then payment would be determined through an independent dispute resolution process. Plan sponsors and administrators may have to negotiate or arbitrate a payment agreement, potentially with the help of a third party, and the protections and processes will need to be reflected in plan documents, summary plan descriptions, and summaries of benefits and coverage. Further guidance will be needed.

Some providers will be permitted to balance-bill their patients in specified circumstances, but only if they notify the patients

The Consolidated Appropriations Act includes provisions aimed at ending surprise billing, enacted as the No Surprises Act.

and obtain *advanced consent*. In those cases, physicians must provide a cost estimate and information about in-network options for receiving the care and get patient consent at least 72 hours before treatment. For shorter-turnaround situations, the law requires that patients receive the consent information the day the appointment is made. This provision is aimed at patients who want to see an out-of-network physician, although many types of physicians will be prohibited from balance billing, including anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons and laboratories. This is allowed only in nonemergency circumstances and only when in-network treatment options are available.

The No Surprises Act also includes several provisions intended to increase information group health plans share with plan participants and patients effective for plan years on or after January 1, 2022, including the following:

- **Information on insurance cards:** Physical and electronic insurance cards issued by health plans must disclose in-network and out-of-network deductibles and out-of-pocket limits. They must also list a phone number or website where patients can obtain information about in-network providers.
- **Advance explanation of benefits (EOBs):** Health plans must provide patients with an advance EOB, which describes the network status of providers and the individual's expected cost sharing.
- **Continuity of care:** For individuals who are a) undergoing treatment for a serious and complex condition, b) pregnant, c) receiving inpatient care, d) scheduled for non-elective surgery or e) terminally ill, a group health plan or health insurance issuer must provide 90 days of continued, in-network care if a provider leaves the plan's network.
- **Price comparison tool:** Health plans must provide a price comparison tool that allows enrolled individuals to compare the amount of cost sharing for which the individual would be responsible.
- **Accuracy of provider directories:** The law establishes requirements for ensuring that provider directories are accurate and up to date. Patients will be protected from out-of-network costs if the directory inaccurately lists a provider as being in network.

Some of the law's provisions overlap with the departments of Health and Human Services (HHS), Labor and Treasury's final rules on transparency in coverage,[1] while other provisions will require new disclosures from plans or insurers to participants that will require additional implementing guidance. Plan sponsors should monitor such guidance to determine action steps needed to comply.

Provider nondiscrimination

The Affordable Care Act (ACA) prohibits group health plans and health insurers from discriminating against any health provider that acts within the scope of its license or certification under applicable state law. Although the departments issued FAQ guidance on this provision, they have not issued implementing regulations. Under the act, final regulations must be issued on or before January 1, 2022, within six months after a 60-day comment period on proposed regulations. Depending on the scope of the guidance, plans will likely need to review and possibly amend the terms of their group health plans.

The No Surprises Act also includes additional reforms aimed at transparency in health coverage, including:

- **Ban on gag clauses relating to cost and quality:** The law prohibits plans from entering into provider contracts that bar, directly or indirectly, the disclosure of provider-specific cost and quality information. An annual attestation from the plan will be required; expected guidance is likely to include more specifics on timing for these filings. The provision also prohibits contractual arrangements that prevent plans from accessing de-identified claims information.
- **Disclosure of broker and consultant compensation:** The law requires that brokers and consultants disclose to group health plan sponsors at the time of contracting any direct or indirect compensation they will receive for services provided to the plan (beginning December 27, 2021, one year after the date of enactment).
- **Mental health parity analysis:** Health plans that offer both medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits will be required to conduct a comparative analysis of the design and application of nonquantitative treatment limitations that apply to those benefits. They must also make the comparative analysis and certain other information available to the Secretary of HHS, Secretary of Labor or state insurance regulator, as applicable, upon request, within 45 days of enactment.

The Consolidated Appropriations Act extends the tax credit for paid family and medical leave through 2025.

- **Drug reporting requirements:** Health plans will be required to provide an annual disclosure regarding certain drug costs and plan information (not later than one year after the date of enactment — December 27, 2021 — and not later than June 1 of each year thereafter). The disclosure will include such information as the number of enrollees in the plan, each state in which the plan operates, the 50 most costly prescribed drugs by total annual spending, the 50 drugs with the greatest increase in plan spending and total spending of health care services by type of cost.

These reforms will require guidance on what must be shared and when (including required government filings for group health plans). Employers should make sure their third-party administrators are aware of these changes and are preparing to comply.

Further, the new law is likely to require group health plans to conduct mental health parity reviews and audits, so plan sponsors will need to review their plan terms for ongoing compliance. The drug reporting requirements overlap with some requirements in the final regulations on transparency in coverage, so plan sponsors will need to work closely with their insurance carriers and pharmacy benefit managers to comply.

Tax provisions

Employer tax credit for paid family and medical leave

The Consolidated Appropriations Act extends the tax credit for paid family and medical leave through 2025. The tax credit was originally enacted as part of the 2017 Tax Cuts and Jobs Act, which added Internal Revenue Code (IRC) section 45S allowing a business tax credit equal to a percentage of the wages an employer pays employees while they are on paid Family and Medical Leave Act (FMLA) leave.[2] In general, to be eligible for the tax credit, an employer must allow all "qualifying" full-time employees at least two weeks of annual paid FMLA leave (and provide leave for part-time employees on a pro rata basis).[3] The tax credit for the employer ranges from 12.5% to 25% of the amount that is paid during the employee's leave, depending on the level of

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

[2] See "**IRS issues guidance on tax credit for paid family and medical leave**," *Insider*, October 2018.

[3] More information on the tax credit can be found on an IRS **dedicated webpage**.

wage replacement provided to eligible employees. Additional limitations apply to the tax credit amount, including that the amount of the paid FMLA leave that may be considered with respect to any employee for a taxable year may not exceed 12 weeks. Note that paid leave provided by a state or local government, or that is required to be provided by state or local law, is *not* considered paid FMLA leave under IRC section 45S. Further, a paid time-off program that can be used for multiple purposes, including for paid FMLA leave, will *not* qualify for the tax credit.

Employers may want to revisit the requirements to receive the tax credit and determine whether to implement a new paid leave program or make changes to an existing program.

Exclusion for certain employer payments of student loans

The act extends for five years, through 2025, a provision allowing employer payments of principal or interest on any qualified education loan of an employee to be excluded from the gross income of that employee. These payments can be made to the employee or to a lender. This provision, enacted by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, amended IRC section 127(c), which pertains to educational assistance programs. The excluded payments are still capped at $5,250 per calendar year per employee, and all other requirements applicable to such plans are still in effect. The $5,250 cap applies to both the new student loan repayment benefit as well as other educational assistance (e.g., tuition, fees, books) provided by the employer under the tax code.

Employers may wish to revisit adopting or expanding the scope of their educational assistance programs. The CARES Act was the first law to allow an employee's student loan to be paid by his or her employer on a tax-favored basis. Employers that want to take advantage of these provisions must have a written educational assistance program that includes student loan repayment during the period this repayment is available. Employers with an existing educational assistance program will have to amend their plan document to adopt the student loan repayment benefit. Note that all the requirements under IRC section 127 for educational assistance plans will continue to apply (e.g., plan documents and nondiscrimination testing).

For comments or questions, contact
Ann Marie Breheny at +1 703 258 7420,
ann.marie.breheny@willistowerswatson.com;
Anu Gogna at +1 973 290 2599,
anu.gogna@willistowerswatson.com; or
Ben Lupin at +1 215 316 8311,
benjamin.lupin@willistowerswatson.com.

News in Brief

Second COVID-19 vaccine added to preventive care guidelines

On December 18, 2020, the Food and Drug Administration (FDA) issued an Emergency Use Authorization for the Moderna COVID-19 vaccine. The following day, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention issued an interim recommendation for use of the Moderna COVID-19 vaccine in persons aged 18 years or older for the prevention of COVID-19.

Previously, on December 11, 2020, the Pfizer-BioNTech COVID-19 vaccine was authorized by the FDA and recommended by ACIP for use in persons aged 16 years or older for the prevention of COVID-19.[1]

In accordance with **interim final regulations** issued in October[2] by the Departments of Labor, Health and Human Services, and Treasury, non-grandfathered group health plans must cover qualifying COVID-19 preventive services, including any vaccine and its administration, without cost sharing, within 15 business days of a recommendation from the United States Preventive Services Task Force (USPSTF) or the ACIP.

The ACIP's recommendation started the 15-business-day period, meaning that non-grandfathered group health plans must begin to cover the Pfizer-BioNTech COVID-19 vaccine with no cost sharing by January 5, 2021, and the Moderna COVID-19 vaccine with no cost sharing by January 12, 2021.

[1] See "**COVID-19 vaccine added to preventive care guidelines**," *Insider*, December 2020.

[2] See "**Regulations on COVID-19 vaccine and testing requirements issued**," *Insider*, November 2020.

CAA requires health plans to demonstrate MHPAEA compliance

By Ben Lupin and Kathleen Rosenow

The Consolidated Appropriations Act, 2021 (CAA), the year-end stimulus and budget law enacted on December 27, 2020, includes a requirement for group health plans providing mental health and substance use disorder (MH/SUD) benefits, as well as medical/surgical (M/S) benefits, to formally analyze and compare nonquantitative treatment limitations (NQTLs) between those benefits. The data and results must be reported to the applicable federal agency — either the Department of Labor (DOL)[1] or the Department of Health and Human Services (HHS), as appropriate — *upon request,* within 45 days of the CAA's enactment. This means the DOL can begin requesting a comparative analysis report from group health plans starting February 10, 2021.

While the Mental Health Parity and Addiction Equity Act (MHPAEA)[2] currently requires group health plans to provide parity between MH/SUD and M/S benefits with respect to quantitative financial and treatment limitations (e.g., copays/coinsurance, visit limits, day limits) and NQTLs (e.g., preauthorization requirements, network sufficiency, medical management standards), the CAA has created more formal analyses and reporting requirements.

Formal NQTL parity comparative analysis

The NQTL analysis required by the CAA must include the following:

- The specific plan terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and M/S benefits to which each such term applies in each respective benefit classification
- The factors used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits
- The evidentiary standards used for the factors identified in the preceding bullet, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and M/S benefits
- The comparative analyses demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTLs to MH/SUD benefits are comparable to, and applied no more stringently than, those same factors used to apply the NQTLs to M/S benefits in the benefits classification
- The specific findings and conclusions reached by the group health plan, including any results of the analyses described above, that indicate that the plan is or is not in compliance with these requirements

The DOL can begin requesting a comparative analysis report from group health plans starting February 10, 2021.

Note that the government regulators must finalize any draft or interim guidance and regulations relating to the NQTL analysis requirements in CAA *within 18 months* after the date of enactment.

Reporting analysis results

Generally, the DOL can request that a group health plan submit the new NQTL comparative analyses for potential violations of the MHPAEA, complaints regarding NQTL noncompliance and "any other instances in which the DOL determines appropriate." The CCA also requires the DOL to request *no fewer than 20* of the NQTL compliance analyses *per year.*

The following briefly describes the process under which an NQTL analysis will be reviewed, as set forth in the CAA:

- If the DOL concludes that the group health plan has not submitted sufficient information for it to review the comparative analyses, the DOL will specify the information the plan must submit to be responsive.
- If the DOL concludes the group health plan is not in compliance, within 45 days of that finding, the group health plan must provide an action plan that it will implement to bring itself into compliance, as well as additional comparative analyses.

[1] The DOL will enforce the provisions for group health plans subject to ERISA.

[2] See "**Final FAQs issued on nonquantitative treatment limits under MHPAEA**," *Insider*, September 2019.

- If, after the 45-day corrective action period, the plan is still found to be noncompliant, the DOL will notify all group health plan participants of the noncompliance within seven days.

The DOL Secretary must submit a report to Congress on December 20, 2021, with a summary of the comparative analyses received, and then no later than October 1 of each year thereafter. That report, available to the public, will include the group health plans and issuers that are not in compliance with the MHPAEA. Also, the DOL is required to share its findings on whether or not a group health plan is in MHPAEA compliance with the states where the group health plan is located.

Going forward

Employers should determine whether MHPAEA analysis (including NQTL analysis) has been conducted (and documented) on their group health plans:

- Those that have conducted a NQTL analysis of their group health plan should determine whether the analysis meets the requirements provided in the CAA and be prepared to report data and results to the DOL.
- Those that have never tested their group health plans for MHPAEA compliance or that need to update testing due to plan design changes should conduct testing and prepare the analysis report as soon as practicable.

It is not yet known whether the DOL will begin reviews before formal implementation guidance is issued. Employers should consult with those knowledgeable in how NQTLs operate in group health plan administration to ensure compliance.

For comments or questions, contact Ben Lupin at +1 215 316 8311, benjamin.lupin@willistowerswatson.com; or Kathleen Rosenow at +1 507 358 0688, kathleen.rosenow@willistowerswatson.com.

Guidance clarifies California law on collecting and reporting pay data

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

The California Department of Fair Employment and Housing (DFEH) has issued **FAQs** that clarify certain issues surrounding a new California law (**SB 973**) that requires covered employers to collect pay and hours worked data and to report that information no later than March 31 of the following year.[1] This equal pay report is similar to the now-rescinded "Component 2" of the federal EEO-1 form that would have required employers to collect and report similar information. Among the important issues clarified in the FAQs is how an employer should determine whether it meets the 100 employee threshold and, as a result, would therefore be required to submit the report.

The following Q&As are intended to help employers start preparing now for filing a timely report and reflect the latest guidance from the DFEH.

Q. Which employers are covered by the new law?

The new law applies to private employers with 100 or more employees that are required to file the EEO-1 form under federal law. The DFEH has confirmed that employers must count employees located both inside and outside of California; however, employers with no employees in California during the reporting year are not required to file a report. The FAQs also clarify that part-time employees are counted the same as full-time employees, and those on employer-approved paid or unpaid leave are also counted.

The DFEH has confirmed that employers must count employees located both inside and outside of California.

A report must be filed if the employer either employed 100 or more employees in the "snapshot pay period" (as described on the following page) or employed on a regular basis 100 or more employees during the reporting year. According to the FAQs, "regular basis refers to the nature of a business that is recurring, rather than constant." The FAQs provide an example: In a seasonal industry, an employer that employs

[1] See "**New California law requires employers to collect and report pay data**," *Insider*, November 2020.

100 or more employees during that season would be required to file a pay data report, if an EEO-1 report is also required to be filed.

Q. Which employees are included in a report?

Employers must submit information based on a snapshot date taken from the end of any pay period between October 1 and December 31. The report must account for and include all employees who were active as of that snapshot pay period, regardless of whether the employee worked for the employer the entire calendar year.

The DFEH also includes a detailed FAQ explaining which employees *must* be included in a report (e.g., employees assigned to California establishments and/or working within California, including teleworkers) and which employees *may* be included (e.g., employees located outside of California, and working for a non-California establishment).

Employers may want to consult legal counsel on whether to report data for employees who neither work at nor are assigned to a California establishment.

Q. When must reports be filed?

The California law requires employers to submit their first report, covering 2020 calendar-year data, by March 31, 2021. Future reports must be filed by March 31 of each subsequent year.

Q. Where are the reports filed and on what forms?

The reports are filed with the California DFEH. Employers with multiple establishments are required to submit a report for each establishment and a consolidated report that includes all employees. The law defines an "establishment" merely as "an economic unit producing goods or services." According to the FAQs, an employer's headquarters is an establishment for purposes of pay data reporting to DFEH.

The DFEH is in the process of creating a "secure online reporting system" and will issue standard reports for employers to use in submitting their information.

Q. What data must be collected and reported?

The report must include two categories of information submitted in a searchable and sortable format:

1. **The number of employees by race, ethnicity and sex in each of the federally identified job categories.** These categories are executive or senior-level officials and managers, first or midlevel officials and managers, professionals, technicians, sales workers, administrative support workers, craft workers, operatives, laborers and helpers, and service workers. Employers will count employees in these groups by creating a snapshot pay period.
2. **The number of employees by race, ethnicity and sex whose annual earnings fall within each of the pay bands used by the U.S. Bureau of Labor Statistics in the Occupational Employment Statistics survey.** The 12 pay bands span from $19,239 and under to $208,000 and over. Employers must submit annual W-2 earnings for each employee identified in the snapshot pay period, regardless of whether the employee worked a full year. Employers must also report total hours worked by each employee within a given pay band during the reporting year.

The California law requires employers to submit their first report, covering 2020 calendar-year data, by March 31, 2021.

Reporting the total number of hours worked for exempt employees, or any employees who do not file time sheets or track hours worked, will be challenging. The DFEH intends to issue further guidance related to hours worked. It's uncertain whether that guidance will permit employers to use a standard number of hours as a default (e.g., 40 hours per week for full-time employees and a lower number for part-time employees) as was done for the Component 2.

The FAQs provide that employers should report employees' sex in three officially recognized categories — female, male and nonbinary — with the preferred identification method being employee self-identification.

Q. What happens with the data?

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

The FAQs provide some additional details about retention and potential publication of submitted data (e.g., in aggregate reports).

Q. Where can employers find more guidance?

Employers should monitor the DFEH website for regularly updated FAQs. The DFEH website indicates that guidance will be posted soon on certain issues not addressed in the initial round of FAQs, including those related to pay; hours worked; multi-establishment employers; and corporate transactions, such as mergers, acquisitions and spinoffs. In addition, employers may submit questions to the DFEH at **paydata.reporting@dfeh.ca.gov**.

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

The same criticisms of the federal EEO-1 Component 2 also apply to the new California law. For instance, some employers have argued that the collection of W-2 earnings will unnecessarily open the door to increased scrutiny and investigations because there are limited opportunities for employers to explain legitimate non-discriminatory reasons for pay disparities (e.g., education, training, experience, tenure, merit). Similarly, the new law also does not take into account certain other differences between jobs, such as eligibility for overtime, commissions and bonuses, and employees working less than the entire year or promoted during the year.

Although employers may provide "clarifying remarks," it is unclear how those might affect enforcement efforts. Employers have also expressed concerns about data privacy as well as the time and resources required to complete a report that may include data that are of limited value.

The FAQs have done little to alleviate these various concerns; in fact, the guidance that addresses the inclusion and calculation of out-of-state employees will likely heighten the time-consuming complexities faced by many California employers.

Q. How should employers start preparing?

Employers should start to determine how they will collect the necessary data by:

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

All employers, even those without any California employees, should be aware that the Biden administration may attempt to reinstitute the Component 2 requirement of the federal EEO-1 form.

Employers will also want to consider conducting a pay equity analysis to 1) identify existing wage differences between employees doing "substantially similar work," 2) evaluate the reasons for the differentials, and 3) make adjustments where necessary.

Finally, all employers, even those without any California employees, should be aware that the Biden administration may attempt to reinstitute the Component 2 requirement of the federal EEO-1 form. If resurrected, all employers that are required to file the federal EEO-1 form will have to collect and report additional pay and hours worked data.

For comments or questions, contact
Stephen Douglas at +1 203 326 6315,
stephen.douglas@willistowerswatson.com;
Rich Gisonny at +1 203 351 5122,
rich.gisonny@willistowerswatson.com;
Laura Rickey at +1 214 530 4215,
laura.rickey@willistowerswatson.com; or
Lindsay Wiggins at +1 213 337 5844,
lindsay.wiggins@willistowerswatson.com.

Supreme Court rules ERISA does not preempt Arkansas PBM law

By Rich Gisonny, Anu Gogna and Ben Lupin

On December 10, 2020, the U.S. Supreme Court held in **Rutledge v. Pharmaceutical Care Management Association** that ERISA *does not* preempt an Arkansas statute that regulates the minimum prices at which pharmacy benefit managers (PBMs) must reimburse pharmacies within the state. Specifically, the court held that the Arkansas PBM law has neither an "impermissible connection with" nor reference to ERISA and is therefore not preempted. At least 38 states have passed laws regulating PBM reimbursement rates that are similar to the Arkansas law.

The Supreme Court's opinion does not specify an effective date. As a result, the decision is currently in effect and will be invoked by other courts if they are asked to rule in similar cases.

Background

In 2015, to address the trend in Arkansas of significantly fewer independent and rural pharmacies, the state legislature adopted Act 900, which mandates that pharmacies be reimbursed for generic drugs at or above the cost the pharmacies paid for the drugs. Further, the law requires PBMs to update their maximum allowable cost lists within at least seven days from the time there has been a certain increase in acquisition costs. Finally, the law contains a "decline-to-dispense" option for pharmacies that will lose money on a specific transaction.

The Pharmaceutical Care Management Association (PCMA), a national trade association representing the 11 largest PBMs in the country, sued Arkansas in federal district court, alleging that Act 900 was preempted by ERISA. In 2017, an Arkansas federal district court ruled that the law was preempted by ERISA to the extent that it applies to PBMs administering ERISA-covered group health plans. Following an appeal of that decision, the 8th U.S. Circuit Court of Appeals agreed that the law was preempted by ERISA in 2018.

Supreme Court's ruling

In an 8 – 0 opinion (with Justice Amy Coney Barrett not taking part), the Supreme Court ruled that "Act 900 is merely a form of cost regulation" that applies equally to all PBMs and pharmacies in Arkansas and therefore is not "impermissibly connected" with an ERISA plan. The court stated that "ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage."

Further, the court stated that a statute refers to ERISA when it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation." The court concluded that Act 900 does not refer to ERISA because it applies to all PBMs regardless of whether the PBM manages an ERISA plan. The court stressed that Act 900 affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract. Crucially, the Arkansas statute applies when PBMs pass along those charges not only to ERISA plans but also to plans provided by Medicaid, Medicare, the military or the marketplace.

The court acknowledged that ERISA plans may pay more for prescription-drug benefits in Arkansas than in another state, creating potential nationwide "inefficiencies" for plan sponsors; however, the court concluded that "creating inefficiencies alone is not enough to trigger ERISA pre-emption."

Going forward

The *Rutledge* decision validates the enforceability of Arkansas' PBM law. It also will indirectly support the enforceability of similar laws in other states and may encourage more states to adopt laws regulating PBM reimbursement rates. Employers should review the terms of their agreements with their PBMs to determine what impact, if any, the ruling would have on prescription drug costs.

Employers also should be aware that some states may view the *Rutledge* decision as an opening to advance additional laws that directly impact the cost of health care, beyond prescription drugs, for ERISA-covered health plans without directly mandating changes to the terms of the plan.

For comments or questions, contact
Rich Gisonny at +1 203 351 5122,
rich.gisonny@willistowerswatson.com;
Anu Gogna at +1 973 290 2599,
anu.gogna@willistowerswatson.com; or
Ben Lupin at +1 215 316 8311,
benjamin.lupin@willistowerswatson.com.

HHS proposes changes to HIPAA privacy rule

By Maureen Gammon and Anu Gogna

The Department of Health and Human Services (HHS), Office for Civil Rights (OCR) recently issued a **Notice of Proposed Rulemaking** and **fact sheet** to announce proposed changes to the Health Insurance Portability and Accountability Act (HIPAA). If adopted, the proposed regulations would make a number of significant changes to the HIPAA privacy rule. The proposed regulations are intended to give individuals greater access to their protected health information (PHI) as well as improve the sharing of an individual's information for care coordination and case management activities. While a number of the proposed changes are more relevant to health care providers, group health plans will also be affected.

The final regulations would be effective 60 days after they are published. As proposed, covered entities would have 180 days after the effective date to comply with any new or modified requirements.

Comments on the proposed regulations are due within 60 days after the date the proposed regulations are published. At the time of this writing, the proposed regulations have not yet been published in the Federal Register but are expected imminently.

Access to PHI

The HIPAA privacy rule currently grants individuals the right to inspect and copy their own PHI that is maintained by a covered entity (e.g., group health plan) in a designated record set. Individuals also have the right to direct an electronic copy of their PHI in an electronic health record to a third party. A number of modifications to these access rights are proposed to reduce barriers to an individual obtaining access to his or her PHI, including:

- Giving individuals the right to take notes, videos and photographs using personal devices or resources to view and capture images of their PHI
- Shortening the time for covered entities to respond to an individual's right to access PHI from 30 days, with a 30-day extension, to "as soon as practicable" but in no case later than 15 calendar days after receipt of the request with the opportunity for an extension of no more than 15 calendar days
- Prohibiting covered entities from imposing unreasonable measures on individuals attempting to access their PHI

The proposed regulations are intended to give individuals greater access to their protected health information.

- Clarifying the required form and format for responding to individuals' requests for their PHI
- Limiting the fees covered entities can charge individuals exercising their right of access and requiring covered entities to post on their websites their estimated fee schedules for providing individuals access to their PHI (the preamble includes a chart that addresses permitted fees for various types of access)
- Requiring covered entities, at the individual's direction, to submit an individual's request to another health care provider and to receive the requested electronic copies of the individual's PHI in an electronic health record
- Requiring covered entities, such as group health plans, to respond to records requests that they receive from other covered entities, such as health care providers, when directed by an individual's request pursuant to the right of access
- Requiring covered entities to inform individuals that they retain their right to obtain or direct copies of PHI to a third party when a summary of PHI is offered in lieu of a copy

Individual care coordination and case management

The HIPAA privacy rule allows covered entities to use and disclose PHI, without an individual's authorization, for purposes of treatment and certain health care operations. The definitions of both treatment and health care operations currently include some care coordination and case management activities. To better facilitate these activities at the individual level, the proposed regulations would clarify the definition of health care operations to encompass all care coordination and case management activities by health plans, whether individual-level or population-based.

The HIPAA privacy rule generally requires that covered entities use, disclose or request only the minimum PHI necessary to meet the purpose of the use, disclosure or request. The proposed regulations would add an exception to

the minimum necessary standard for care coordination and case management activities at the individual level, regardless of whether such activities constitute treatment or health care operations.

Notice of privacy practices

Covered entities are required to provide a notice of their privacy practices (NPP) to each individual who is the subject of PHI. The proposed regulations would modify the content requirements of the NPP. Specifically, the proposed regulations would require that the NPP notify individuals of the following:

- How to access their health information
- How to file a HIPAA complaint
- Their rights to receive a copy of the notice and to discuss its contents with a designated person

When final regulations are issued, covered entities would need to revise their NPP to incorporate the new language, as well as designate and identify in the NPP specific contact information for a person with whom individuals may discuss the NPP.

Going forward

While the regulations are currently only in proposed form and no immediate action is required, employer-sponsored group health plans should review the proposed rules and decide whether to submit comments to HHS.

Once final rules are adopted, employer-sponsored group health plans will need to review their HIPAA privacy policies and procedures, particularly as they relate to the rights of individuals to their PHI and how to exercise those rights, and update as necessary. Covered entities will also need to modify their NPPs and train their workforce on the new policies and procedures.

For comments or questions, contact Maureen Gammon at +1 610 254 7476, maureen.gammon@willistowerswatson.com; or Anu Gogna at +1 973 290 2599, anu.gogna@willistowerswatson.com.

EEOC issues proposed amendments to wellness rules

By Anu Gogna, Ben Lupin and Kathleen Rosenow

The Equal Employment Opportunity Commission (EEOC) has issued proposed rules on wellness programs under the **Americans with Disabilities Act** (ADA) and the **Genetic Information Nondiscrimination Act** (GINA) in response to a decision of the U.S. District Court for the District of Columbia that vacated a portion of the previously issued EEOC wellness regulations.[1]

As background, the ADA wellness regulations set forth rules with respect to the incentives employers may offer as a part of wellness programs that ask about employees' health (i.e., make a disability-related inquiry) and/or ask employees to undergo medical examinations, while the GINA wellness regulations set forth rules with respect to the incentives that may be offered to an employee whose spouse provides information about the spouse's manifestation of disease or disorder as part of a wellness program.

The proposed ADA wellness regulations include the following provisions:

- The regulations would apply only to the portion of wellness programs that include "medical examinations" (e.g., biometric screenings) and "disability-related inquiries" (e.g., health risk assessments). Wellness programs that do not include disability-related inquiries or medical examinations would *not* be subject to the proposed rule.
- The regulations generally would limit incentives to encourage employees to take part in a wellness program that includes disability-related inquiries and/or medical examinations to no more than de minimis incentives (e.g., "a water bottle or gift card of modest value"). The EEOC is seeking comments on the definition of "de minimis" for these purposes, including whether it would be helpful to provide additional examples of de minimis incentives as well as examples of incentives that would violate the de minimis limit (e.g., a paid annual gym membership or free airline tickets).
- The regulations provide an exception to the de minimis incentive rule for *health-contingent programs* that include disability-related inquiries and/or medical examinations that are subject to the Health Insurance Portability and

[1] See "**EEOC wellness update and planning for 2019**," *Insider*, May 2018.

Accountability Act (HIPAA)/Affordable Care Act (ACA) wellness rules and are offered through a group health plan. In that case, the wellness program would be subject to the incentive limits currently permitted under the HIPAA/ACA wellness rules (and not the de minimis rule). The EEOC notes that such a wellness program would need to adhere to all the other requirements of voluntariness specified in the ADA rules as well as the five requirements to be a health-contingent program under HIPAA/ACA.

- The regulations provide that because the EEOC believes it is proposing a de minimis wellness incentive standard for most wellness programs, it is no longer necessary to require employers to issue a unique ADA notice (i.e., the notice required under the ADA wellness regulations published on May 17, 2016).

In addition, the proposed GINA wellness regulations would also limit wellness program incentives to no more than de minimis incentives (e.g., "a water bottle or gift card of modest value") in return for the employee's family members providing information about the family members' manifestation of diseases or disorders to a wellness program (e.g., under a health risk assessment).

Employers sponsoring wellness programs should review the proposed regulations and may wish to provide comments to the EEOC.

Going forward

Employers sponsoring wellness programs should review the proposed regulations and may wish to provide comments to the EEOC during the 60-day comment period, which begins the date the proposed rules are published in the Federal Register. Further, employers sponsoring wellness programs should monitor whether President Biden's administration makes any changes in the final regulations as well as the timing for implementation in the final regulations before updating their current wellness program design.

For comments or questions, contact
Anu Gogna at +1 973 290 2599,
anu.gogna@willistowerswatson.com;
Ben Lupin at +1 215 316 8311,
benjamin.lupin@willistowerswatson.com; or
Kathleen Rosenow at +1 507 358 0688,
kathleen.rosenow@willistowerswatson.com.

2019 asset allocations in Fortune 1000 pension plans

Overview of the 2019 Asset Allocation Study of Fortune 1000 Pension Plans

By Mercedes Aguirre, Brendan McFarland and Verónica Vassallo

The year 2019 ended with both equity and bond markets posting the strongest investment gains since 2003, boosting plan sponsors' plan asset values; however, interest rates ended the year at historically low levels, increasing liabilities and offsetting most of the asset growth realized over the year. Employer contributions in 2019 were smaller than in prior years, leaving most plans' funding performances contingent on the sponsor's investment strategy.

In 2020, the market has experienced drastic shifts mostly due to COVID-19 economic repercussions. After a severe equity downturn during March 2020, interest rates hit a new low during the summer, emphasizing the level of risk plan sponsors are exposed to and their impeding need to stay on top of volatile financial markets. Sponsors need to adapt to the new normal characterized by high-volatility scenarios, consolidating the implementation of de-risking strategies — both in terms of asset allocation/strategies and risk transfer activities — balanced with their need to maintain a level of asset growth that can cover liabilities and fund further pension risk transfers.

The Financial Accounting Standards Board began requiring more detailed pension disclosures in 2009, and Willis Towers Watson has been analyzing asset allocations ever since.[1] These analyses track asset allocation trends and patterns over time in Fortune 1000 plans. This 11th edition looks at fiscal year-end 2019 pension allocations by asset class, such as cash, equity, debt and alternatives, as well as by a variety of other attributes of both the assets and the plans.

The analysis is performed on both an aggregate-sponsor (weighted by plan assets) and average-sponsor basis as well as by plan size, plan status (open, frozen or closed) and

[1] See "**2016 Asset allocations in Fortune 1000 pension plans**," *Insider*, January 2018.

Figure 1a**. Aggregate asset distribution by class and level, 2019**

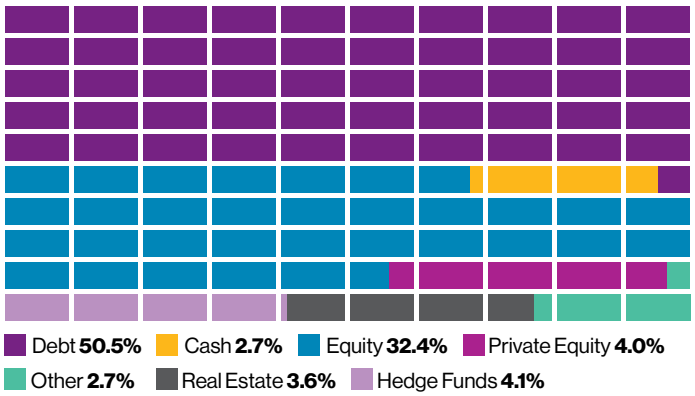
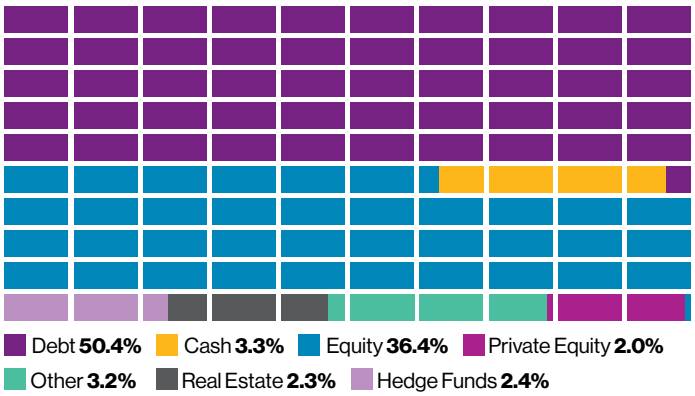


Figure 1b**. Average asset distribution by class and level, 2019**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

funded status (defined as the ratio between total fair value of assets over total liabilities, considering both U.S. and non-U.S. plans). We examine the prevalence and amount of pension assets invested in company securities. Finally, we compare asset holdings from 2009 through 2019 for a consistent sample of plan sponsors and examine the relationship between risk-reduction strategies and asset allocations.

Analysis highlights

- Sponsors in this analysis closed 2019 with an almost unchanged aggregate funding status of 87% compared with the 86% funding level by year-end 2018. Equity and bond market performances were some of the strongest realized in more than a decade, which was almost completely offset by record low interest rates that increased liability values.
- There is a strong correlation between a pension plan's status and its portfolio's risk profile, with frozen plans holding more liability-hedging investments compared with closed and open plans. On average, frozen pension plans held almost 60% of their assets in fixed income and cash versus only 50% for sponsors of open plans.
- Over the past decade, the shift from equities to fixed-income investments has been consistent. Since 2009, average allocations to public equities declined by roughly 16 percentage points, while allocations to debt increased by close to the same amount. Sponsors show a gradual search for returns via alternative investments (including hedge funds, private equity and real estate), which increased from 6.1% in 2009 to 8.5% in 2019.
- The use of alternative investments (hedge funds, private equity and real estate) has a high correlation with the plan's size. While larger plans allocated 10.3% to alternative investments, smaller plans only hold around 3.6% of their portfolio in these same investment vehicles.
- In 2019, around 7% of Fortune 1000 defined benefit (DB) plan sponsors held pension assets in the form of company securities, and among that group, such securities averaged 5.0% of plan assets.

2019 aggregate and average asset allocations

Willis Towers Watson's analysis of 2019 fiscal year-end DB plan asset allocations first takes a detailed look at 448 Fortune 1000 plan sponsors' pension disclosures.[2, 3]

Figure 1a summarizes aggregate asset allocations weighted by the value of the sponsor's plan assets and shows total-dollar allocations. As of year-end 2019, the 448 companies in this analysis held more than $1.9 trillion in pension assets, composed of cash, public equity, debt and alternative investments (real estate, private equity, hedge funds and other).

At year-end 2019, 32.4% of pension assets were allocated to public equity and 50.5% were allocated to debt, with the remaining assets spread among the other various categories.

Figure 1b depicts average asset allocations (not weighted by plan assets) for the same companies. The average Fortune 1000 pension plan sponsor in the analysis held roughly $4.3 billion in assets at year-end 2019.

[2] The analysis consists of those Fortune 1000 DB plan sponsors that provided comprehensive asset allocation disclosures in their annual reports and that managed assets for domestic pensions.

[3] In previous studies, asset allocation analysis differentiated among the three levels under which fair value of assets is measured. Since the standard of reporting under Net Asset Value (NAV) became available to companies a couple of years ago, sponsors have increasingly been switching their valuation level to NAV (30% of aggregate assets surveyed were reported under NAV); therefore, this approach was discontinued from our analysis.

The average allocation to public equity was 36.4% (versus an aggregate allocation of 32.4%), while the average debt allocation was 50.4%. As for alternative assets — real estate, private equity, hedge funds and other investments — allocations averaged 9.9%, while aggregate allocations were 14.4%. The difference between the aggregate and the average reflects differences in plan size: Larger plans were more likely than smaller plans to invest in alternatives and less likely to invest in public equity.

When we consider allocations in real estate, hedge funds and private equity combined as alternative investments, we found that 65.4% of sponsors held alternative assets in their asset allocation mix. The share allocated to the different type of alternatives held in this category is very evenly divided, with hedge funds amounting to 34.7%, private equity accounting for 34.6% and real estate 30.7% (Figure 2a). In 2019, among those that held alternatives, 36% of sponsors with alternative investments held up to 5% of their assets in these types of investments, while 3.4% of sponsors held more than 30% of their assets in real estate, private equity and/or hedge funds (Figure 2b).

During 2019 average public equity holdings and debt holdings remained almost unchanged, experiencing slight increases of less than one percentage point (0.1 and 0.4 percentage points, respectively). In a consistent sample of 399 plan sponsors from 2018 to 2019, more than half of sponsors (56%) realized increases in their equity holdings while a similar portion of these sponsors (55%) witnessed decreases in their share of debt investments (Figure 3).

While roughly half of plan sponsors showed increases in their equity holdings of 10.0% or less, only 36.1% showed similar increases in their debt allocations. These movements seem to be the result of strong market returns without a change in portfolio rebalancing.

Figure 2a. **Aggregate asset distribution within alternative investments, 2019**

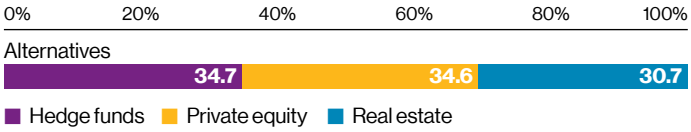
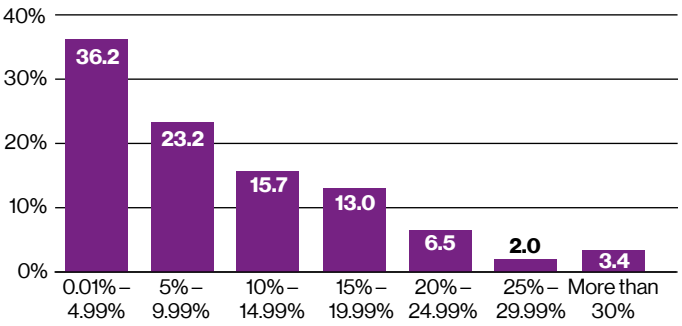


Figure 2b. **Distribution of companies by allocation to alternative assets, 2019**



Source: Willis Towers Watson

While roughly half of plan sponsors showed increases in their equity holdings of 10.0% or less, only 36.1% showed similar increases in their debt allocations. These movements seem to be the result of strong market returns without a change in portfolio rebalancing.

Figure 3. **Average annual changes in equity and debt allocations, 2019**

Change magnitude	Equity allocations		Debt allocations	
	% of sponsors realizing a change in their equity allocations	Average change realized in equity allocations	% of sponsors realizing a change in their debt allocations	Average change realized in debt allocations
Increase of over 10%	**6.0%**	**17.1%**	**8.5%**	**20.5%**
5% – 9.9% increase	**8.0%**	**6.6%**	**10.0%**	**7.1%**
0% – 4.9% increase	**41.9%**	**2.2%**	**26.1%**	**2.1%**
No change	**2.5%**	**0%**	**0.5%**	**0%**
0% – 4.9% decrease	**25.8%**	**–2.0%**	**41.6%**	**–2.0%**
5% – 9.9% decrease	**9.8%**	**–7.3%**	**7.5%**	**–6.9%**
Decrease of over 10%	**6.0%**	**–19.1%**	**5.8%**	**–21.9%**

Source: Willis Towers Watson

Figure 4a. **Aggregate asset allocations by plan size, 2019**

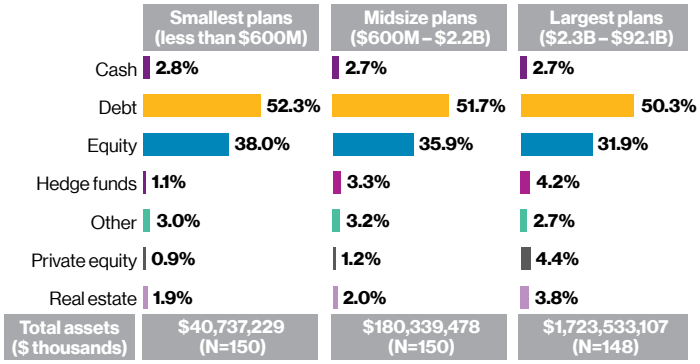
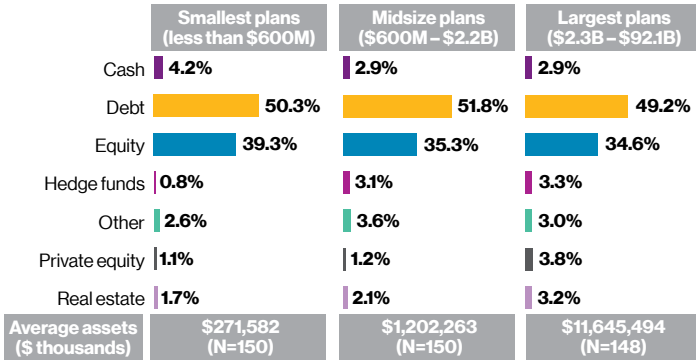


Figure 4b. **Average asset allocations by plan size, 2019**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

Asset allocations by plan size

Aggregate and average asset allocations for smaller, medium and larger plan sponsors are shown in Figures 4a and 4b. The analysis divides these sponsors into three equal groups by total pension assets: Smaller plan sponsors held less than $600 million, midsize plan sponsors held between $600 million and $2.2 billion, and large plan sponsors held more than $2.3 billion. The largest sponsor held pension assets worth more than $92 billion. Weighting smaller, medium and larger sponsors by plan assets emphasizes the large share of pension assets held by very large plans[4] as well as the pronounced differences in investing behavior between smaller and larger plans (Figure 4a).

The larger the plan, the lower the allocation to public equity, which averaged 34.6% for large plans versus 39.3% for small plans (Figure 4b). This difference is even more striking for aggregate allocations. Overall, larger plans allocated less to public equities and more to alternative investments (real estate, private equity and hedge funds). On average, larger plans allocated more than twice as much as smaller plans to other return-seeking investments (13.3% versus 6.2%), which might reflect larger plans' access to economies of scale and in-house investment structures that enable them to effectively manage alternative assets. Despite differences in plan size, the three groups of sponsors held more than 50% of their assets in fixed-income investments, evidencing a common path toward de-risking among all DB plan sponsors.

Asset allocations by plan status

For this part of the analysis, we divided plan sponsors into three mutually exclusive categories by the current status of their primary pension plan: open, closed to new hires or frozen. Open DB plans are those still offered to newly hired employees, while closed plans stopped being offered to new hires after a fixed date. In frozen plans, accruals by service, pay or both have ceased for plan participants. Roughly three-quarters of the companies in our analysis sponsored either a closed or a frozen pension plan, while the remaining still offered open plans.

Figures 5a and 5b show asset allocations by plan status and demonstrate a relationship between the plan's current status and the portfolio's risk profile, with the correlation strongest on an aggregate basis (Figure 5a). Frozen pensions held more risk-averse investments compared with plans – either open

[4] The 10 largest plans held 30.3% of all plan assets.

Figure 5a. **Aggregate asset allocations by plan status, 2019**

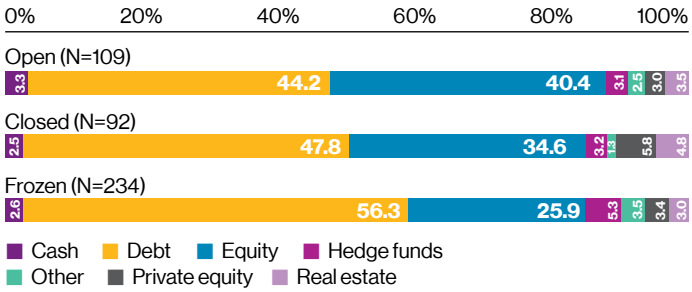
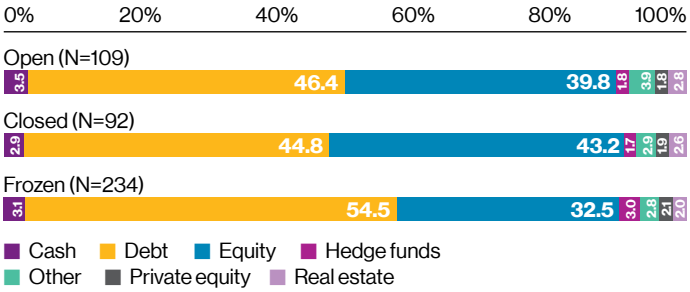


Figure 5b. **Average asset allocations by plan status, 2019**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

Figure 6a**. Average asset allocations by plan funded status, 2019**

Asset class	Funded status				
	Less than 70%	70% to 79%	80% to 89%	90% to 99%	100% or more
Cash	5.0%	2.5%	2.4%	3.1%	3.8%
Debt	46.9%	42.6%	50.2%	54.9%	58.7%
Equity	40.4%	41.8%	35.1%	33.8%	31.2%
Hedge funds	2.2%	4.3%	2.6%	1.8%	1.5%
Other	3.2%	3.1%	3.6%	2.2%	1.9%
Private equity	0.7%	2.9%	3.0%	1.5%	1.8%
Real estate	1.6%	2.8%	3.1%	2.7%	1.1%
Total %	100%	100%	100%	100%	100%
N	44	82	104	82	54

Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Soure: Willis Towers Watson

Same as last year, average debt holdings surpassed equity investments across all funding levels, evidencing the sponsors' continuous efforts toward de-risking.

or closed — in which workers were still actively accruing pensions. In aggregate, sponsors of frozen plans held almost 59% of their assets in fixed income and cash versus only 47.5% for sponsors of open plans.

Asset allocations by funded status

During fiscal year 2019, plan sponsors witnessed exceptionally strong market returns (Figure 7, next page) that were expected to materialize into significant improvements for their pension funding levels. Unfortunately, interest rates dropped on average close to one percentage point, increasing the value of pension obligations. The net effect of these offsetting forces affecting funding levels were tepid but positive, and sponsors of Fortune 1000 DB plans closed the year with an aggregate funding status of 87%, practically unchanged when compared with the 86% at the end of 2018.

Our 2019 analysis shows a correlation between funded status and asset allocations (Figure 6a). As sponsors get closer to full funding levels, their portfolios tend to become more conservative in nature, typically as a result of investment de-risking strategies such as liability-driven investment (LDI) and asset glide paths.[5] Same as last year, average debt holdings surpassed equity investments across all funding levels, evidencing the sponsors' continuous efforts toward de-risking.

While plans tend to become more risk averse as their funded status nears full funding, a closer look also uncovers a further link between debt allocations and benefit accruals.[6] Figure 6b depicts the relationship between higher allocations to debt as well as the plan's funded status and benefit accrual rate. Well-funded plans with lower benefit accrual rates are typically associated with higher allocations to fixed-income

[5] LDI strategies typically use fixed-income assets as a hedge against interest-rate-driven movements in plan liabilities. In years when long-term, high-quality corporate bond interest rates decline, with corresponding increases in plan obligations, corporate bonds will produce positive returns and vice versa. In a glide path strategy, future target allocations are based on the plan's funded status, with the sponsor shifting assets from equities to debt as funding levels climb to mitigate risk and volatility.

[6] The accrual rate is the ratio between the pension's service cost and the year-end projected benefit obligation.

Figure 6b**. Allocations to debt by funded status and benefit accrual rates, 2019**

Accrual rate	Funded status									
	Less than 70%		70% to 79%		80% to 89%		90% to 99%		100% or more	
	N	Debt %	N	Debt %	N	Debt %	N	Debt %	N	Debt %
Less than 0.5%	14	38.0%	31	47.7%	51	55.2%	31	63.6%	30	65.1%
0.5% to 0.99%	8	51.3%	17	41.1%	19	55.7%	17	61.5%	7	63.1%
1.0% to 1.9%	16	49.8%	26	40.7%	33	49.0%	34	48.8%	9	53.4%
2.0% to 2.9%	12	40.7%	13	41.0%	12	46.7%	12	47.9%	8	38.8%
3.0% or more	8	44.4%	9	36.6%	9	36.3%	3	41.2%	6	54.3%
N	58		96		124		97		60	

Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.
Source: Willis Towers Watson

assets, while higher accrual rates (reflecting active pensions) correspond with higher allocations to return-seeking assets.

Pension assets held in company securities

Around 6.7% of Fortune 1000 DB plan sponsors held company securities as pension assets in 2019. These allocations averaged 5.0% of pension assets in 2019 (4.9% when weighted by end-of-year plan assets). The weighted average is lower than the simple average because larger plans allocated lower percentages to company securities than did smaller plans.

Almost 7% of these sponsors explicitly noted plan contributions in the form of company securities in 2019.

In 2019, company securities constituted 4% or less of pension assets in 56.7% of these plans and made up more than 10% of pension assets in 13.3% of them (Figure 7).[7]

Trends in allocations since 2009

We next track asset allocation trends from the past decade, based on a consistent sample of 202 pension sponsors that have been in the Fortune 1000 over the past 10 years. Figures 8a and 8b show asset allocations for these companies on an aggregate and average basis for 2009, 2013, 2017 and 2019.

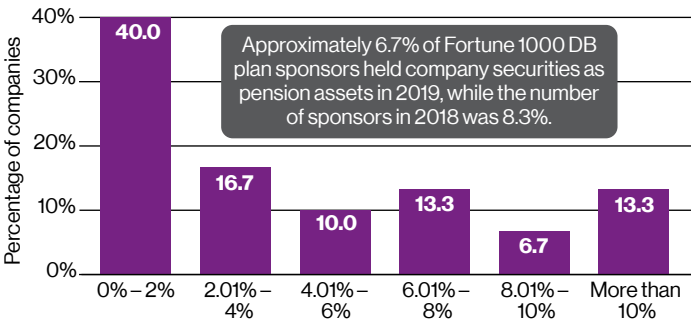
The shift from equities to fixed-income investments has been consistent throughout the period. Since 2009, average allocations to public equities declined by 15.3 percentage points, while allocations to debt increased by roughly the same amount. Sponsors show a gradual search for asset growth via other return-seeking assets, with allocations to alternatives (including hedge funds, private equity and real estate) increasing from 6.5% in 2009 to 8.5% in 2019.

The total number of sponsors holding private equity and real estate in their alternative assets portfolios has increased from 30.7% and 48.5% in 2009 to 46.5% and 52.5% in 2019, respectively. Not only has the prevalence of companies holding these assets as part of their alternatives portfolio increased, but also the average holdings have ticked up slightly over the same period. Looking only into those plan sponsors with real estate assets in their portfolios, property investments represented an average of 3.5% of total plan assets in 2009 but ticked up to 5.0% in 2019. Similarly, private equity holdings in 2009 averaged 5.4%, while by year-end 2019 the average was 6.2%.

[7] To promote asset diversification, pension law does not allow U.S. DB plans to invest more than 10% of pension assets in company securities.

The shift from equities to fixed-income investments has been consistent [over the past decade].

Figure 7. **Allocations to company stock, 2019**



Source: Willis Towers Watson

Figure 8a. **Aggregate asset allocations by investment class for consistent sample of Fortune 1000 companies (%), 2009, 2013, 2017 and 2019**

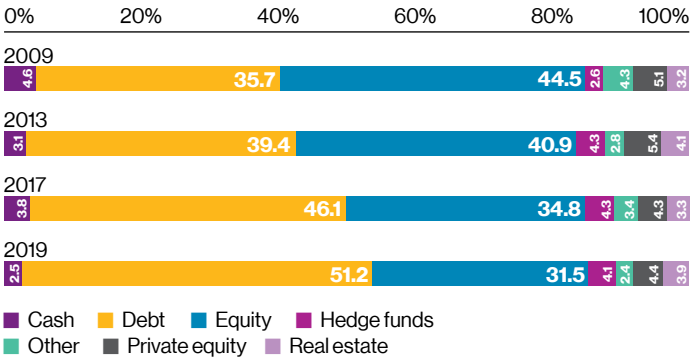
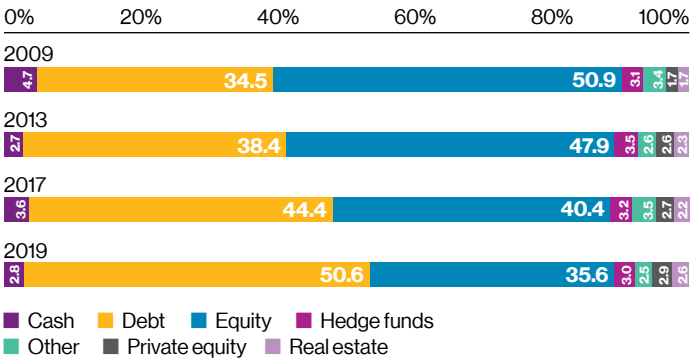


Figure 8b. **Average asset allocation by investment class for consistent sample of Fortune 1000 companies (%), 2009, 2013, 2017 and 2019**



Notes: Cash includes cash equivalents and money market instruments; debt includes insurance contracts, and hedge fund assets include derivatives and interest rate swaps.

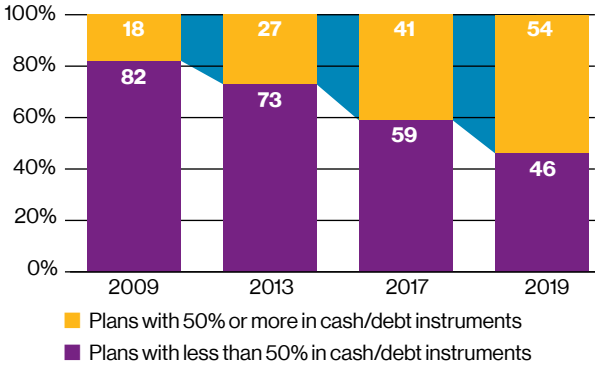
Source: Willis Towers Watson

Asset de-risking

Between 2009 and 2019, among a consistent sample of 202 sponsors, the number of plans whose pensions held 50% or more in cash and fixed-income assets tripled, rising from 18% to 54% (Figure 9). On average, this group has shown a significant increase of their liability-hedging investments holdings, going from 39.2% of cash and debt in 2009, up to 53.3% in 2019.

The analysis shows a clear de-risking trend, with plan sponsors focusing more on hedging liabilities and less on higher returns. Many sponsors have complemented de-risking via asset allocation strategies with other liability-reduction strategies, such as offering lump sum buyouts, purchasing annuities and terminating their plans.

Figure 9. **Prevalence of companies with more than 50% of pension assets in cash/debt instruments for consistent sample of Fortune 1000 companies, 2009, 2013, 2017 and 2019**



Source: Willis Towers Watson

Conclusion

The year 2019 was another year in which sponsors watched exceptional asset returns get mitigated by further declining interest rates used to measure pension obligations. These movements working in tandem left sponsors with minor increases in pension funding levels on average.

Overall, we have found that all types of sponsors have continued to move in the direction of a more conservative portfolio. In terms of plan size, all groupings analyzed have more than 50% invested in fixed-income assets. When looking at sponsors from their plan status perspective, all sponsors show average allocations to fixed-income assets of 45% or more, with frozen plans being the furthest down a de-risking path (58% on average). Finally, although over-funded and nearly funded plans are the most tilted toward fixed-income assets (62.5% and 60.7%, respectively), all funding buckets have on average more than 44% allocated to these low-volatility investment holdings.

During 2020, sponsors have thus far endured a tumultuous ride, with estimated funding levels dropping drastically in the first quarter due to equity market declines, only to see the following equity market recovery being offset by further declines in interest rates that hit new historic lows. Given some of the commentary by central banks around intentions for future interest rates, sponsors will need to consider the effects current market conditions may have as they evaluate their options for improving funded status and managing risk, either via investment strategy, funding policy or further de-risking transactions.

For comments or questions, contact Mercedes Aguirre at +598 2 626 2510, mercedes.aguirre@willistowerswatson.com; Brendan McFarland at +1 703 258 7560, brendan.mcfarland@willistowerswatson.com; or Verónica Vassallo at +598 2 626 2514, veronica.vassallo@willistowerswatson.com.

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