EMPLOYEE BENEFITS MANAGEMENT
Directions

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INSIDE

Supreme Court has opportunity to clarify state regulation of PBM practices in pending landmark case, expert says

LINDA CLARK

ERISA preemption issues have been litigated for decades. A recent case, *Rutledge v. Pharmaceutical Care Management Association*, which involves a state's right to regulate pharmacy benefit managers (PBM), is now before the Supreme Court. Because the Eighth Circuit's decision in *Rutledge* conflicts with decisions of other courts of appeals, the Supreme Court's ruling could have national implications. To find out more about the case, **Wolters Kluwer** reached out to Linda Clark, partner and health care controversies team leader at Barclay Damon.

WK: What is the role of pharmacy benefit managers?

Clark: A pharmacy benefit manager (PBM) is a third-party administrator of prescription-drug programs for more than 270 million Americans who have health insurance. PBMs act as "middle-men" by negotiating with health care plans, drug manufacturers, and pharmacies to set drug pricing for consumers and determining how much pharmacies are reimbursed. They essentially leverage their status to maximize profits while simultaneously harming American pharmacies and increasing costs to patients. PBMs are involved in drug utilization review, drug plan formulary review, exclusionary practices of pharmacies, reimbursement rates, and negotiation of rebates and discounts from drug makers specifically affecting consumer out-of-pocket costs.

In theory, a PBM should keep its interests in line with health care consumers. In practice, a lack of transparency and regulation is alarming given that the cost of health care continues to rise and drug costs are at an all-time high. For example, CVS Health is poised as the second largest PBM, but its chain of retail pharmacies leaves its independence somewhat questionable. The next largest PBM, OptumRx, is a subsidiary of UnitedHealth Group, America's largest health care provider. It begs the question: how can a PBM with clear conflicts manage numerous prescription plans affecting millions of consumers and manage a network within which it actively competes? As a result of these relationships smacking of conflicts and anticompetitive practices, PBMs are making billions of dollars per year with little to no federal regulation or oversight at the expense of consumers and pharmacists who suffer from stifled competition and growing PBM monopolies.

WK: What is the prevalence of state regulation of PBMs?

Clark: Recently, PBMs have faced growing scrutiny about their role in rising prescription drug costs and spending due to the Trump Administration's May 11, 2018, report titled "Blueprint to Lower Prices and Reduce Out-of-Pocket Costs." In the name of lowering drug costs and in an attempt to increase transparency in PBM practices, state lawmakers have begun to draft legislation calling for enforcement of legislative action against PBMs.

Wolters Kluwer

In 2018, the U.S. Congress passed the Patient Right to Know Drug Prices Act (S. 2554), which would end practices that prohibit pharmacists from telling customers they could save money by paying cash out-of-pocket rather than using their insurance. Congress also approved a bill (S. 2553), titled "Know the Lowest Price Act of 2018" banning gag clauses in Medicare. As of May 2019, there are a total of 33 states that enacted laws prohibiting gag clauses restricting pharmacies from disclosing when the price or copay of a drug is more than the cash price. Furthermore, there are at least 20 states that have enacted "anti co-pay claw back" provisions that aim at preventing numerical price overcharges to patients buying retail drugs in a pharmacy.

Unfortunately, we are far from full transparency. Spread pricing, or the difference (spread) between the amount charged to a plan and the amount reimbursed to a pharmacy, is another unscrupulous practice that has allowed for millions of dollars to be retained by PBMs. In 2018, Ohio conducted an audit of its managed care organizations that contract their prescription benefit plans to PBMs. The state attorney general's report found that while the overall spread in 2017 was $224.8 million, or 8.9%, a significant portion of the spread occurred on generic drugs. The PBMs charged the state a spread of more than 31% for generic drugs that comprised more than 86% of all prescriptions.

Many states are awaiting the U.S. Supreme Court's ruling on the *Rutledge v. Pharmaceutical Care Management Association* case, which would address the scope of states' authority to regulate PBMs, waiting to see what the permissible scope of state regulation will be. For example, in 2019, New York's Governor Andrew Cuomo vetoed legislation (S. 6531) that would provide the superintendent of insurance regulatory authority over PBMs coincidentally at the same time as the U.S. Supreme Court requested input from the U.S. Solicitor General on whether to hear *Rutledge*.

WK: What is the *Rutledge* case about?

Clark: In 2015, the Arkansas General Assembly enacted Act 900 to regulate PBMs reimbursing pharmacists for prescription drugs dispensed to insurance beneficiaries. Act 900 included mandates for pharmacy reimbursement for drug costs, new requirements for PBMs' updates to maximum allowable cost lists, and administrative appeal procedures. Before the enactment of Act 900, PBMs were found to reimburse pharmacies at less than a pharmacy's cost to acquire a drug, causing more than 16 percent of rural pharmacies in Arkansas to close in recent years.

In 2015, the Pharmaceutical Care Management Association (PCMA), a trade association representing PBMs, filed a lawsuit to block enforcement of Act 900. U.S. District Judge Brian Miller ruled Act 900 was preempted by the federal Employee Retirement Income Security Act (ERISA), and, in 2018, the U.S. Court of Appeals for the Eighth Circuit affirmed Judge Miller's ruling. Thereafter, Arkansas Attorney General Leslie Rutledge petitioned the U.S. Supreme Court in November 2018 to review the Eighth Circuit's ruling and seek to save community pharmacies from abusive PBM payment practices.

Most importantly, the Supreme Court's anticipated decision will decide whether PBM groups can continue to avoid regulation and litigation simply by shielding themselves using the 'go to' ERISA preemption argument and will also serve to address conflicting decisions by a federal appeals court on ERISA state law preemption.

WK: Why did the Supreme Court agree to hear the case?

Clark: As states step up their efforts to control prescription drug prices, many state legislatures have begun to pass legislation targeting draconian PBM practices by introducing legislation to bring greater transparency to the inner workings of PBMs. As a result of these efforts, however, states increasingly face challenges from the pharmaceutical industry, specifically the Pharmaceutical Care Management Association (PCMA). Over the years, PCMA has brought a number of lawsuits challenging state legislation regulating PBMs, claiming that ERISA preempts such legislative actions.

The *Rutledge* case has been a long time coming, dating back to 2014 and a case called *PCMA v. Gerhart*.[1] In *Gerhart*, the PCMA filed its first lawsuit against an Iowa state law regulating PBM practices arguing preemption by ERISA, which sets minimum standards for voluntarily established retirement and health plans in the private sector. Ultimately, after the district court dismissed PCMA's lawsuit, PCMA appealed to the U.S. Court of Appeals for the Eighth Circuit. The Eighth Circuit ultimately reversed the district court's ruling and held, in 2017, that Iowa's law was preempted by ERISA.

In 2015, PCMA filed its second lawsuit against an Arkansas law arguing the law was preempted by ERISA. In 2017, the Eighth Circuit held that the Arkansas law was again preempted by ERISA and in response, the Arkansas Attorney General's Office filed a petition with the U.S. Supreme Court to review

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Editors
Lauren Bikoff, MLS
Tulay Turan, JD

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Publishing Production & Design Services

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the Eighth Circuit's ruling. In 2019, the U.S. Supreme Court requests the input of the U.S. Solicitor General. Surprisingly, the Solicitor General filed a brief on behalf of the United States arguing the Eighth Circuit decision was wrongly decided and urging the Supreme Court to take the case. Ultimately, in 2020, the U.S. Supreme Court agreed to issue a decision that could have far-reaching implications regarding states' authority to regulate PBMs.

The U.S. Supreme Court ultimately decided to take on the case as these decisions out of the Eighth Circuit deepened the circuit split.[2]

The Eighth Circuit's decisions conflicted with decisions from the First and D.C. Circuits, which upheld materially identical PBM laws. The First Circuit essentially ruled that PBMs are "peripheral ERISA players that no law regulating them is preempted" and therefore ERISA never preempts generally applicable PBM regulations.[3] Likewise, the D.C. Circuit previously concluded that everything PBMs do is "so central to plan administration that PBMs are imperious to state regulation."[4] Due to these conflicting rulings, the U.S. Supreme Court sought to resolve the split in authority.

WK: What are the parties' arguments?

Clark: *Arkansas Attorney General Leslie Rutledge*

Rutledge argues that state laws regulating the relationship between PBMs and pharmacies are not preempted by ERISA as laws, such as Act 900, are not specifically focused on ERISA plans and are meant to only regulate the relationship between PBMs and pharmacies, not the ERISA plans themselves. Thus, such relationships are so attenuated and unrelated to ERISA that they could not be connected to plan administration. Furthermore, a ruling of preemption has far-reaching implications, and especially where ERISA could be used to preempt state laws regulating everything having to do with "medical care." Lastly, a blanket finding of preemption whenever a state law regulates PBMs that manage benefits for entities, including ERISA plans, risks insulating PBMs from state regulations.

PCMA

PCMA argues that Act 900 creates inefficiencies in employer-sponsored health plans and threatens access to prescription drugs. PCMA further argues that the act eliminates important tools that help employers, through PBMs, manage prescription drug costs and provide access to medications. PCMA argues these matters are central to plan administration, and protecting ERISA's promise of uniformity is more critical than ever as ERISA has long enabled employers to provide uniform benefit plans to employees nationwide due to ERISA's preemption of state laws.

WK: How is the ERISA preemption issue the same or different from prior cases?

Clark: As stated previously, there is a string of similar ERISA challenges out of multiple circuit courts of appeal that shed light on how the court may rule in this case.

PCMA v. Rowe (2003)

Maine's Unfair Prescription Drug Practices Act, enacted in 2003, was one of the first PBM laws in the nation to be challenged by PCMA on ERISA grounds. The law, still in effect today, requires PBMs to disclose any payments they receive from pharmaceutical companies and to pass discounts they receive from pharmaceutical companies on to their clients and to serve as a fiduciary for their clients. On appeal, the First Circuit Court of Appeals affirmed the lower court's decision and held that the Maine law was neither unconstitutional nor preempted by ERISA.[5] In June 2006, the U.S. Supreme Court denied review of the decision,[6] thereby upholding the PBM law.

PCMA v. District of Columbia (2004)

The year after Maine's law was enacted, the District of Columbia enacted a similar PBM law, which PCMA quickly challenged. Title II of the Access Rx Act of 2004 requires PBMs to act as fiduciaries, disclose the content of their contracts with pharmacies and manufacturers, and pass on any payments or discounts they receive from pharmacies or manufacturers. The Court of Appeals for the D.C. Circuit ultimately struck down key provisions of the law on the basis of ERISA preemption.[7]

PCMA v. Gerhart (2014)

Ten years later, in 2014, Iowa passed an Act Relating to the Regulation of Pharmacy Benefits Managers (Iowa Code § 510B.8), which revived PCMA's arduous ERISA challenges. The law was passed in an effort to regulate generic drug pricing and mandated disclosures in drug pricing methodology. In January 2017, on appeal from the federal district court's ruling to dismiss the case, the Eighth Circuit reversed,[8] holding unanimously that the Iowa law impermissibly interferes with the PBM function of ERISA plans operating in Iowa, as it "imposes mandates and restrictions on a PBM's relationship with Iowa and its pharmacies that run counter to ERISA's intent of making plan oversight and plan procedures uniform."

PCMA v. Rutledge (2015)

Following the lawsuit in Iowa, Arkansas enacted Act 900 in 2015, which required disclosure of generic drug pricing and also sets a floor on prices that PBMs can pay to pharmacies for generic drugs. Unfortunately, the legal decision of the preemption challenge that ensued also mirrored the Iowa case. Closely following the Eighth Circuit decision in *Gerhart* rendered just two months earlier, the District Court of Arkansas struck down the Arkansas law in March 2017.[9]

The Eighth Circuit then affirmed on appeal.[10] Arkansas filed a petition for certiorari, requesting the U.S. Supreme Court to review the case, citing split circuit court decisions in the matter of ERISA preemption of PBM laws among the First Circuit, Eighth Circuit, and D.C. Circuit, which created "'confusion and uncertainty' about state power to regulate drug prices."

Federal ERISA preemption of state PBM legislation has been a longstanding issue debated across the country, with circuit courts reaching opposite rulings in different jurisdictions.

WK: How do you expect the Supreme Court to rule in *Rutledge* and why?

Clark: The Supreme Court asking the U.S. solicitor general to weigh in on the states' petition for certiorari is indicative of the court's interest in *Rutledge.* The solicitor general has taken the position that Arkansas's Act 900 was

not preempted by ERISA, which could be a good sign for independent pharmacies. In his brief to the U.S. Supreme Court, Solicitor General Noel Francisco disagreed with the Eighth Circuit decision, stating that the ruling was contrary to higher court's precedent and should be reviewed and corrected. In essence, the brief agreed with the attorneys general from 31 states and the District of Columbia that would like to see the U.S. Supreme Court reverse the Eighth Circuit's ruling. The solicitor general further argued there is no distinction between regulating PBM administration, which is not preempted by ERISA, and regulating plan administration, which could lead to preemption under ERISA. To the extent it affects health plans, the solicitor general adds the law is not specifically focused on ERISA plans and regulates only the relationship between PBMs and pharmacies—not the ERISA plans themselves.

It is our hope that the U.S. Supreme Court will provide clarity on state regulation of PBM practices and ultimately hold that ERISA does not preempt states from regulating PBMs.

WK: How might the ruling affect other states' efforts to regulate PBMs?

Clark: *Rutledge v. PCMA* is a landmark case that can lead to meaningful regulations on PBMs across the country. PBMs have been relying on ERISA preemption to avoid meaningful oversight by states for years. If the U.S. Supreme Court was to rule in favor of Arkansas, states would be empowered to enact legislation to regulate PBMs and the role they have in our health care system so that their citizens can make informed decisions with respect to their health care choices.

The conduct of PBMs has consistently jeopardized the safe and efficient delivery of prescription drugs to patients. Without laws like in Arkansas—the intent of which was to ensure transparency and patient access—pharmacies will have a harder time operating in an already challenging marketplace and from a disadvantageous position. Most importantly, without legislative oversight, PBMs will continue to operate without oversight and regulations, continuing to set and control drug prices and foster an imbalance in market power.

Because of their unrealistic and predatory tactics and their growing monopoly power, PBMs have been accused of setting unfair standards such as unilaterally determining reimbursement rates for pharmacies, imposing a bar on information pharmacies may share with clients, and steering clients to their owned pharmacies.

WK: Could the ruling affect state regulation of benefits in general and, if so, how?

Clark: The court's ruling could affect a plethora of avenues including, insurance benefits and pricing, drug pricing, health plan offerings, and drug administration. Imagine transparency in health care systems, where pricing, coverage, and dispensing criteria are available to all actors of the health care chain. ■

Endnotes

1 *PCMA v. Gerhart*, No. 14-cv-345 (D. Iowa), on appeal, No. 15-3292 (8th Cir.).
2 *PCMA v. Rutledge*, No. 15-cv-510 (E.D. Ark.), on appeal, No. 17-1609 (8th Cir.), pet. for cert. granted, No. 18-540) (U.S.).
3 *PCMA v. Rowe,* 429 F.3d 294 (1st Cir. 2005).
4 *PCMA v. D.C.*, 613 F. 3d 179 (D.C. Cir. 2010).
5 *PCMA v. Rowe*, 429 F.3d 294 (1st Cir. 2005).
6 *PCMA v. Rowe*, U.S., No. 05-1297 (2006).
7 *PCMA v. Dist. of Columbia*, 613 F.3d 179, 392 U.S. App. D.C. 14, 49 EBC 1609 (D.C. Cir. 2010).
8 *PCMA v. Gerhart*, 2017 BL 7351, 8th Cir., No. 15-3292.
9 *PCMA v. Rutledge,* No. 15-cv-510 (E.D. Ark.).
10 *PCMA v. Rutledge*, 852 F.3d 722, (8th Cir. 2017).

FFCRA

After federal court partly invalidates FFCRA rules, DOL makes regulatory changes

In the aftermath of a New York federal district court's August 3, 2020, ruling invalidating certain aspects of the temporary rule on Families First Coronavirus Response Act requirements, the Labor Department has issued "revisions and clarifications to the temporary rule," which were effective immediately upon publication in the *Federal Register* on September 16.

Temporary FFCRA rule. On April 6, 2020, the DOL published a temporary rule implementing public health emergency leave under Title I of the Family and Medical Leave Act (FMLA), and emergency paid sick leave to assist working families facing public health emergencies arising out of the COVID–19 global pandemic. The leave is created by a time-limited statutory authority established under the FFCRA that is set to expire on December 31, 2020. The temporary rule was effective April 2, but the DOL had issued the unpublished temporary rule on April 1.

Court ruling. On August 3, a court in the Southern District of New York ruled that four parts of the temporary rule are invalid:

- The requirement under § 826.20 that paid sick leave and expanded family and medical leave are available only if an employee has work from which to take leave;
- The requirement under § 826.50 that an employee may take FFCRA leave intermittently only with employer approval;
- The definition of an employee who is a "health care provider," set forth in § 826.30(c)(1), whom an employer may exclude from being eligible for FFCRA leave; and

- The statement in § 826.100 that employees who take FFCRA leave must provide their employers with certain documentation *before* taking leave.

Rule changes. The DOL said that it has carefully examined the court's opinion and has reevaluated the portions of the temporary rule that the court held were invalid. Given the statutory authorization to invoke exemptions from the usual requirements to engage in notice-and-comment rulemaking and to delay a rule's effective date, the time-limited nature of the FFCRA leave benefits, the urgency of the COVID-19 pandemic, and the associated need for FFCRA leave, and the pressing need for clarity in light of the decision, the DOL has issued this new temporary rule, effective immediately, to reaffirm and revise its regulations in part, and further explain its positions.

The changes to the temporary rule are as follows:

- **Available work.** Reaffirm that paid sick leave and expanded family and medical leave may be taken *only* if the employee has work from which to take leave. The DOL said this requirement applies to all qualifying reasons to take paid sick leave and expanded family and medical leave.
- **Intermittent leave.** Reaffirm that where intermittent FFCRA leave is permitted by regulations, employees must obtain their employer's approval to take paid sick leave or expanded family and medical leave intermittently under § 825.50, which the DOL says is consistent with longstanding FMLA principles governing intermittent leave.
- **"Health care provider" redefined.** Revise the definition of "health care provider" under § 825.30(c)(1) to mean employees who meet that definition under the FMLA regulations or who are employed to provide diagnostic services, preventative services, treatment services, or other services that are integrated with and necessary to the provision of patient care which, if not provided, would adversely impact patient care.
- **Notice.** Revise § 826.100 to clarify that the information employees must give their employer to support their leave should be provided to the employer as soon as practicable and revise § 826.90 to correct an inconsistency concerning when employees may be required to give notice of expanded family and medical leave to their employer.

"As the economy continues to rebound, more businesses return to full capacity, and schools reopen, the need for clarity regarding the Families First Coronavirus Response Act paid leave provisions may be greater than ever," Wage and Hour Administrator Cheryl Stanton said in a press release. "Today's updates respond to this evolving situation and address some of the challenges the American workforce faces. Our continuing robust response to this pandemic balances support for workers and employers alike, and remains our priority." ■

SOURCE: *85 FR 57677, September 16, 2020.*

LATEST INTEREST RATES

IRS IRS
October AFRs
Period for Compounding

	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-term				
AFR	0.14%	0.14%	0.14%	0.14%
110% AFR	0.15%	0.15%	0.15%	0.15%
120% AFR	0.17%	0.17%	0.17%	0.17%
130% AFR	0.18%	0.18%	0.18%	0.18%
Mid-term				
AFR	0.38%	0.38%	0.38%	0.38%
110% AFR	0.42%	0.42%	0.42%	0.42%
120% AFR	0.46%	0.46%	0.46%	0.46%
130% AFR	0.49%	0.49%	0.49%	0.49%
150% AFR	0.57%	0.57%	0.57%	0.57%
175% AFR	0.67%	0.67%	0.67%	0.67%
Long-term				
AFR	1.12%	1.12%	1.12%	1.12%
110% AFR	1.23%	1.23%	1.23%	1.23%
120% AFR	1.34%	1.34%	1.34%	1.34%
130% AFR	1.47%	1.46%	1.46%	1.46%

30-year Treasury Securities Rate

Month	*Yield Rate*
August 2020	1.36%

Yield Curve and Segment Rates

Spot Rates	*First Segment*	*Second Segment*	*Third Segment*
August 2020	0.52%	2.22%	3.03%

24-Month Average without adjustment by 25-year segment rates

September 2020	2.22%	3.38%	3.92%

Adjusted 24-Month Average

September 2020	3.64%	5.21%	5.94%

Minimum Present Value Segment Rates

	First Segment	*Second Segment*	*Third Segment*
August 2020	0.52%	2.22%	3.03%

PBGC

Rates for valuing benefits of terminating single-employer and multiemployer plans
For plans with a valuation date on or after
October 1, 2020 1.62%

Rates for valuing lump sums for PBGC payments
For plans with a valuation date on or after
October 1, 2020 0.00%

Rates for valuing lump sums for private sector payments
For plans with a valuation date on or after
October 1, 2020 0.00%

Variable rate premium for single-employer plans
For premium payment years beginning in

	First Segment	*Second Segment*	*Third Segment*
September 2020	0.52%	2.22%	3.03%

OPEN ENROLLMENT

Most Americans plan on spending more time reviewing benefits due to COVID-19, Voya survey finds

The majority of working Americans will be looking to their workplace benefits for health and wealth support due to COVID-19, especially as they prepare for open enrollment in the midst of a global pandemic. That's according to a survey from Voya Financial, Inc.

While most working individuals (84%) believe that their core benefits (e.g. medical, vision and dental) are sufficient in helping cover unplanned medical expenses, Voya's new survey also found that roughly 7 in 10 employees (71%) plan to spend more time reviewing voluntary benefit options offered by their employers as a result of COVID-19 than they did during the last enrollment period. Plus, more importantly, the survey reveals that more than half (53%) plan to make changes to their benefits coverages.

"With COVID-19 part of our daily lives for the foreseeable future, our new survey reveals that many are focused on ways that they can protect the health and wealth of themselves and their families, and they recognize workplace benefits are a way to do just that," said Rob Grubka, president of Employee Benefits, Voya Financial. "As a result, this upcoming open enrollment season — which typically occurs in the fall for millions of Americans — presents an opportunity for individuals to rethink and revaluate previously untapped benefits offered by their employer. This is not the year for employees to hit the 'default button' on their workplace benefits, and I find it encouraging to see that more working Americans plan to take positive steps during their next open enrollment period."

When asked which employee benefits would help better manage their current needs, health savings accounts (HSAs) or flexible spending accounts (FSAs) were mentioned by nearly 4 in 10 surveyed employees (38%) — followed by 35 percent of employees selecting supplemental health benefits like hospital indemnity insurance, critical illness insurance, or short-term and long-term disability income insurance.

From a generational standpoint, interestingly, GenZ had the highest level of agreement when it came to wanting more information about their benefits, expecting to spend more time reviewing their benefits and planning to make benefits changes. Specific findings include:

- **Want more information from their employer outside of enrollment period:** GenZ had the highest level of agreement at 82 percent, Millennials at 79 percent, GenX at 77 percent and Baby Boomers at 70 percent.
- **Will spend more time reviewing their workplace benefits:** GenZ had the highest level of agreement at 83 percent, Millennials at 72 percent GenX at 71 percent and Baby Boomers at 63 percent.
- **Plan on making changes to their benefits:** GenZ was significantly more likely to agree at 74 percent versus other generations — Millennials at 60 percent, GenX at 53 percent and Baby Boomers at 28 percent.

"As the youngest and newest workers, it makes sense that GenZ would be most engaged on benefits as they have had the least amount of time in the workforce, less familiarity with employee benefits options and limited experience making employee benefit decisions compared to older colleagues," said Grubka. "The pandemic has presented employers with a unique opportunity to help educate GenZ about the value of workplace benefits early in their careers, during a time when — historically — individuals tend to be less concerned with their health and financial wellness needs."

Despite generational differences, the survey also points out that it will be key for all American workers to follow through with their intentions to make benefits decisions during their next open enrollment period. While top of mind, nearly half of benefit-eligible individuals (49%) indicated that they would rather plan a home improvement project or review their home cable and internet options versus only 37 percent who said they are most likely to review their employee benefits and health insurance options offered through their employer.

"It's understandable — especially as more Americans are working from home — to want to focus your energy on home improvements versus reviewing your workplace benefits," said Grubka. "But the survey also finds that becoming more financially secure is the top priority for nearly half of American workers (49%) as life eventually shifts back to normal — cited more frequently than spending additional time with family and friends (41%), leading a healthier lifestyle (40%) and traveling somewhere new (25%). A good place to start to help achieve this goal is by looking closer at the benefits offered by your employer — especially in the midst of a global pandemic." ■

SOURCE: *voya.com*

FRINGE BENEFITS

2021 per diem rates issued for travel expense reimbursements

The IRS has provided the 2020-2021 special per diem rates for taxpayers to use to substantiate ordinary and necessary business expenses incurred while traveling away from home. The guidance provides the special transportation industry meal and

incidental expenses (M&IE) rates, the rate for the incidental expenses only deduction, and the rates and list of high-cost localities for purposes of the high-low substantiation method.

Transportation industry. The special M&IE rates for taxpayers in the transportation industry are $66 for any locality of travel in the continental United States (CONUS) and $71 for any locality of travel outside the continental United States (OCONUS).

The rate for any CONUS or OCONUS locality of travel for the incidental expenses only deduction is $5 per day.

High-low method. For purposes of the high-low substantiation method, the per diem rates are $292 for travel to any high-cost locality and $198 for travel to any other locality within CONUS. The amount of the $292 high rate and $198 low rate that is treated as paid for meals is $71 for travel to any high-cost locality and $60 for travel to any other locality within CONUS. The per diem rates in lieu of the M&IE only substantiation method are $71 for travel to any high-cost locality and $60 for travel to any other locality within CONUS.

High-cost localities. The following localities have been added to the list of high-cost localities: Los Angeles, California; San Diego, California; Gulf Breeze, Florida; Kennebunk/Kittery/Sanford, Maine; Virginia Beach, Virginia.

The following localities have changed the portion of the year in which they are high-cost localities: Sedona, Arizona; Monterey, California; Santa Barbara, California; District of Columbia (see also Maryland and Virginia); Naples, Florida; Jekyll Island/Brunswick, Georgia; Boston/Cambridge, Massachusetts; Philadelphia, Pennsylvania; Jamestown/Middletown/Newport, Rhode Island; Charleston, South Carolina.

The following localities have been removed from the list of high-cost localities: Midland/Odessa, Texas; Pecos, Texas.

Effective date. This notice is effective for per diem allowances for lodging, meal and incidental expenses, or for meal and incidental expenses only, that are paid to any employee on or after October 1, 2020, for travel away from home on or after October 1, 2020. For purposes of computing the amount allowable as a deduction for travel away from home, this notice is effective for meal and incidental expenses or for incidental expenses only paid or incurred on or after October 1, 2020. IRS Notice 2019-55 is superseded. ■

SOURCE: *IRS Notice 2020-71, I.R.B. 2020-40, September 18, 2020.*

PAID LEAVE

Nationwide approach to paid leave is needed, comment letters say

The COVID-19 pandemic has highlighted the need for a uniform, nationwide approach to paid leave and has put a spotlight on the patchwork of state and local requirements that arise in the absence of a federal solution, according to a comment letter to the Department of Labor from Mercer. In July, the DOL issued a request for information on paid leave. The DOL said the information will help "identify promising practices related to eligibility requirements, related costs, and administrative models of existing paid leave programs."

Mercer noted that employers, particularly multi-jurisdiction employers, are struggling in a time of crisis to understand the compliance requirements of numerous different laws, while trying to support their workforce in a consistent and meaningful way. For instance, the comment letter noted that while the Families First Coronavirus Response Act developed a nationwide emergency paid leave program, many state and local government thought it did not go far enough. "As a result, at least 10 states and over 15 municipal governments have passed emergency paid leave requirements or expanded current paid family and medical leave programs or accrued paid sick leave mandates," Mercer noted.

The comments emphasize that a nationwide voluntary paid family and medical leave compliance standard would improve the current patchwork landscape and lead to a more consistent approach. Such a compliance option could increase the prevalence and value of paid leave benefits, reduce costs, and enhance employees' experience.

"A voluntary federal standard would be welcome relief for employers that have been working to address their employees' need for paid leave benefits, and for those that have increased resources devoted to handling state and local leave administration," Mercer wrote. "Absent a federal solution or improved consistency among state mandates, Mercer expects employers will continue to resist future state mandates as cost and complexity threatens to outpace value."

American Benefits Council. The American Benefits Council also submitted a comment letter to the DOL on paid leave. Like Mercer, the Council recognizes the importance of paid leave benefits, and most member companies provide some sort of paid leave to their workforces.

The American Benefits Council supports federal legislation to expand access to paid leave, consistent with the following principles, among others:

- Employers must have the ability to treat similarly situation workers equitably, wherever they work.
- Federal standards for paid leave programs must ensure that employers operating in more than one jurisdiction are not subject to the cost and administrative burden of

complying with various state or local paid leave requirements that may be inconsistent or even contradictory.
- The federal standards for national employers must be reasonable, affordable, and administrable.
- Employers that adopt and comply with federal paid leave standards must be deemed to be in compliance with all state or local paid leave requirements.
- Employers should have flexibility to design and administer innovative paid leave benefits since what is best suited for one company's workforce or industry may not be best suited for another. ■

SOURCE: *www.mercer.com; www.americanbenefitscouncil.org*

401(K) PLANS

401(k) loan, distribution rules expanded due to COVID-19 pandemic

Q *Have there been any extensions to the 401(k) plan loan repayment rules due to the COVID-19 pandemic?*

A Under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (P.L. 116-136), an additional year for repayment of loans from eligible retirement plans (not including IRAs) is permitted and limits on loans are relaxed. Specifically, if a loan is outstanding on or after March 27, 2020, and any repayment on the loan is due from March 27, 2020 to December 31, 2020, that due date may be delayed under the plan for up to one year. In addition, for plan loans that were made to a qualified individual from March 27, 2020 to September 22, 2020, the limit may be increased up to the lesser of: (1) $100,000 (minus outstanding plan loans of the individual), or (2) the individual's vested benefit under the plan.

Under IRS FAQs, the IRS notes that it is optional for employers to adopt the expanded distribution and loan rules of the CARES Act. An employer is permitted to choose whether, and to what extent, to amend its plan to provide for coronavirus-related distributions and/or loans that satisfy the CARES Act provisions. Even if an employer does not treat a distribution as coronavirus-related, a qualified individual may treat a distribution that meets the requirements to be a coronavirus-related distribution as coronavirus-related on the individual's federal income tax return.

Note, too, that the CARES Act expanded the distribution levels from qualified plans and IRAs. A coronavirus-related distribution is a distribution that is made from an eligible retirement plan to a qualified individual from January 1, 2020 to December 30, 2020, up to an aggregate limit of $100,000 from all plans and IRAs. The distributions generally are included in income ratably over a three-year period, starting with the year in which the distribution is received. However, there is an option of including the entire distribution in income for the year of the distribution. The 10% additional tax on early distributions does not apply to any coronavirus-related distribution, according to the IRS.

SOURCE: *https://www.irs.gov/newsroom/coronavirus-related-relief-for-retirement-plans-and-iras-questions-and-answers*