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The Year-End Appropriations and COVID-19 Act – Provisions Impacting Employee Benefits

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Overview

- Consolidated Appropriations Act of 2021 and COVID-Related Tax Relief Act of 2020 (the "Act') signed into law December 27, 2020
- Provisions Providing Coronavirus-Related Relief
- Provisions Providing Systemic Changes to Employee Benefits
- Plan Amendments

Provisions Providing Coronavirus-Related Relief

- Partial Plan Terminations
- Coronavirus-Related Distributions
- Disaster-Related Distribution and Loan Changes
- Flexible Spending Account Changes
- Reimbursement of Student Loan Expenses

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Partial Plan Terminations

- Code Section 411(d)(3)
  - 100% vesting for affected participants if a retirement plan incurs a “Partial Plan Termination”
  - Partial Plan Terminations occur when there is a significant reduction in the number of active participants in a plan as a result of an employer-initiated termination of employment
- The Act provides relief from the general rule in Section 411(d)(3)
  - Under the Act, a plan will not have a Partial Termination for any plan year that includes the period beginning on March 13, 2020 and ending March 31, 2021, if the number of active participants under the plan as of March 31, 2021 is at least 80% of the plan’s active participants as of March 13, 2020

Coronavirus-Related Distributions

- CARES Act
  - Permitted certain retirement plans to offer participants affected by COVID-19 the opportunity to elect pre-termination distributions of up to $100,000
  - Not subject to 15% additional tax on distributions prior to age 59½
  - Included in income over a three-year period and may be repaid to the plan within three years
  - Available through December 30, 2020
- The Act
  - Permits coronavirus-related distributions from money purchase pension plans
  - Retroactive to January 1, 2020
  - Did **not** extent the availability beyond December 30, 2020

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Disaster-Related Distributions and Loan Changes

- Special distribution and loan rules similar to the rules for coronavirus-related distributions and loans provided for in the CARES Act
  - For federally-declared disasters declared from January 1, 2020 through February 25, 2021
    - Other than the COVID-19 pandemic disaster
  - These are optional changes

Flexible Spending Account Changes

- The Act temporarily liberalizes the rules for health and dependent care flexible spending accounts ("FSA")
  - Election Changes: FSAs may permit election changes for plan years ending in 2021 without regard to whether the employee has had a change in status that would permit an election change under the generally applicable FSA rules
    - Extension of previous IRS relief
  - Unused Balances:
    - FSAs (including dependent care FSAs) may permit participants to carry over unused balances from 2020 to 2021 and 2021 to 2022. There is no cap on this carryover provision
    - FSAs may permit an employee who has ceased participation in the FSA to receive reimbursement from unused balances through the end of the plan year in which the cessation occurred, including grace periods
  - Grace Periods: FSAs may extend grace periods for 2020 and 2021 for up to 12 months following the close of the plan year
  - Special Rules for Dependent Care FSAs: Dependent Care FSAs may reimburse childcare expenses in connection with 13 and 14 year old children in certain circumstances

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Reimbursement of Student Loan Expenses

- Code Section 127 plans generally allow employers to provide educational assistance benefits up to the $5,250 annual limit on a tax-free basis
- The CARES Act permitted these plans to reimburse eligible employee's student loan payments up to the annual limit on a tax-free basis through December 31, 2020
- The Act permits employers to extend this benefit through December 31, 2025

Plan Amendments

- Employers may implement the changes before actually adopting amendments to reflect them
- For changes affecting 2020, an amendment must, generally, be adopted by December 31, 2021
- For changes affecting 2021, an amendment must, generally, be adopted by December 31, 2022

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Provisions Providing Systemic Changes to Employee Benefits

- New Rules Regarding Surprise Medical Billing
- Patient Choice Provisions
- Fee Dispute Resolution Process
- New Rules Providing Transparency in Health Care
- Continuity of Care
- Parity in Mental Health and Substance Use Disorder Benefits

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New Rules Regarding Surprise Medical Billing

- Emergency Services: If a group health plan or insurance issuer covers emergency room services, it must cover such services:
  - Without the need for prior authorizations;
  - Regardless of whether the provider or facility is a participating provider or facility; and
  - If provided by a nonparticipating provider or facility, then without a greater cost sharing requirement to the participant (applied towards deductible), and subject to certain payment timing rules
- Non-Emergency Services Performed by Nonparticipating Providers at Certain Facilities: If a group health plan or insurance issuer covers such services, it must cover such services:
  - Without a greater cost sharing requirement to the participant (applied towards deductible) and as if the total amount that would have been charged to the participant was for services by a participating provider, and subject to certain payment timing rules
- Air Ambulance Services by Nonparticipating Providers: If a group health plan or insurance issuer covers these services from participating providers, then it must cover such services from nonparticipating providers:
  - Without a greater cost sharing requirement to the participant (applied towards deductible) and as if the total amount that would have been charged to the participant was for services by a participating provider, and subject to certain payment timing rules
- External Review: The claims procedure external review provisions applicable to group health plans and insurance issuers must be extended to the surprise medical billing provisions as well
- Effective for plan years or contracts entered or renewed on or after January 1, 2022

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Patient Choice Provisions

- Choice of Primary and Pediatric Care Professionals: If a group health plan or insurance issuer requires or provides for designation of such provider, it must allow each participant to designate any provider available to accept the participant
- Access to Obstetrical and Gynecological Care: A group health plan or insurance issuer may not require authorization or referral in the case of a participant who seeks coverage for obstetrical or gynecological care by a participating professional specializing in such field
- Effective for plan years or contracts entered into or renewed on or after January 1, 2022

Fee Dispute Resolution Process

- Process to Determine Out-of-Network Rates to be Paid by Health Plans: With respect to items or services furnished by a non-participating provider or facility for which a payment is required to be made by the plan or coverage:
  - 30 days for the parties to openly negotiate
  - If no resolution during open negotiation, then within 4 days of the end of the open negotiation process a party may initiate the independent dispute resolution process
    - Notice to other party and to Department of Health and Human Services ("HHS")
    - Certified IDR entity determines payment
    - Process still to be established
- Patient and Provider Dispute Resolution
  - No later than January 1, 2022 HHS will establish a process for uninsured individuals and health care providers and facilities to resolve disputes regarding the amount such individual is required to pay
    - Only applies to uninsured individuals that received a good-faith estimate of expected charges from the provider or facility and then was billed an amount substantially in excess of the estimate

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Transparency Related Provisions

- In and Out-of-Network Deductibles and Limitations: Group health plans and insurance issuers must include, in clear writing, on any physical or electronic plan or insurance identification card issued to participants in the plan or coverage the following:
  - any deductible for the plan or coverage;
  - any out-of-pocket maximum limitation applicable to such plan or coverage; and
  - a telephone number and internet website address through which such individual may seek consumer assistance information
- Advance Cost-Estimates:
  - For plan years beginning on or after January 1, 2022, group health plans and insurance issuers must provide notices to participants scheduled to receive services including information regarding contracted rates for the service and good faith estimates.
  - This notice must be provided no later than 3 business days after the plan or coverage receives notice the service was scheduled, or no later than 1 business day if scheduled less than 10 days in advance

Transparency Related Provisions ctd.

- Information to be Provided Upon Request and for Scheduled Appointments:

  Beginning January 1, 2022, health care providers and facilities must
  - Inquire if an individual scheduling an item or service is enrolled in a group health plan or insurance coverage, and provide a notification in clear and understandable language of the good-faith estimate of the expected charges
  - This needs to be done at least 1 business day before the scheduled appointment if such appointment was scheduled at least 3 business days in advance
  - If the appointment is scheduled 10 days in advance, or the individual requests such information, such inquiry and notification must be provided no later than 3 business days after the date of scheduling or request
- Maintenance of Price Comparison Tool
  - Effective for plan years beginning on or after January 1, 2022, group health plans and insurance issuers must offer price comparison guidance by phone and make a price comparison tool available on their website, showing the amount of cost-sharing that the individual would be responsible for paying with respect to an item or service

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Transparency Related Provisions ctd.

- Provider Directory Information: For plan years beginning on or after January 1, 2022, group health plans and insurance issuers must:
  - Establish a database on its website that lists each provider and facility that has a contractual relationship with the plan and directory information for the provider and facility
  - Update or verify the information every 90 days
    - Cost-sharing relief due to reliance on inaccurate information
- Provider's Responsibility for Accuracy of Directory Information: Beginning no later than January 1, 2022, providers and facilities must establish processes to ensure the timely provision of directory information to the plan or coverage
  - Cost-sharing relief due to reliance on inaccurate information

Transparency Related Provisions ctd.

- Protections from Balance Billing: For plan years beginning on or after January 1, 2022 group health plans and insurance issuers must make publicly available, post on its website, and include on each explanation of benefits:
  - Information in plain language regarding the requirements and prohibitions on balance billing in certain circumstances, including information that may be required by state law; and
  - Information for contacting appropriate federal or state agencies in the case an individual believes a balancing billing protection has been violated
- Prohibition on Gag Clause for Price and Quality Information:
  - Group health plans and insurance issuers may not enter agreements with providers or other similar entities that would directly or indirectly restrict the plan or issuer from:
    - Providing provider-specific cost or quality of care information;
    - Electronically accessing de-identified claims; or
      - Consistent with privacy protections
    - Sharing such information or data with a business associate
      - Consistent with privacy protections
  - Similar requirement for health insurance issuers offering individual health insurance coverage
  - Attestation of compliance to HHS

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Continuity of Care

- Various requirements are imposed on group health plans and insurance issuers when the contractual relationship between an individual's provider or facility and the plan or coverage are terminated, including that such individuals can elect continued transition care from a provider or facility under the same terms and conditions for a certain period of time

- In these circumstances providers and facilities must accept payment and continue to adhere to the plan or issuer's policies

Parity in Mental Health and Substance Use Disorder Benefits

- Parity in Mental Health and Substance Use Disorder Benefits: If a group health plan or insurance issuer provides both medical and surgical benefits and mental health or substance use disorder benefits that impose nonquantitative treatment limitations ("NQTLs") on the mental health or substance use disorder benefits, then the plan or issuer must perform and document comparative analyses of the design and application of the NQTLs, and upon request, make the same available to federal and state authorities

- Reporting Pharmacy Benefits and Drug Costs: Group health plans and insurance issuers will be required to make a report to the federal government with information regarding pharmacy benefits and drug costs

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Questions?

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