Employee Benefits and the Consolidated Appropriations Act:

What Employers and Benefits Professionals Need to Know About the New Law

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HEALTH PLANS
No Surprises Act

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Overview

- Consolidated Appropriations Act, 2021 ("CAA")
  - Enacted December 27, 2020
  - Not to be confused with the Consolidated Appropriations Act, 2021 and Other Extensions Act
- Parallel Provisions
  - Public Health Service Act (enforced by HHS/CMS)
  - ERISA (enforced by DOL/EBSA)
  - Internal Revenue Code (enforced by Treasury/IRS)
- Covered ERISA Plans: Same rules as ACA coverage
  - Covers major medical plans. Does not cover excepted benefit plans (stand-alone dental, stand-alone vision, most EAPs, most health FSAs, most retiree medical plans, etc.).
  - Most provisions apply to grandfathered plans.
- Effective Date:
  - Generally effective for plan years beginning on or after 1/1/22.
  - Some specific dates by which regulations or guidance must be issued.

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Basic Coverage Requirements—Emergency

- If a group health plan covers in-network emergency services, then it must also cover out-of-network emergency services.
  - Plan must not have preauthorization requirements for such services.
  - Plan must have same cost-sharing requirements for both in-network and out-of-network services.
  - Plan must apply any cost-sharing amounts to both in-network deductibles and in-network out-of-pocket maximums.
  - Plan must calculate out-of-network cost-sharing as if the total charge is: (i) the amount required by state law; or if none then (ii) the median contracted rate of the plan sponsor (or issuer) for the same or similar item or service in the same geographic region and the same market as of 1/30/19, increased by CPI-U.
  - Plan must make its initial payment or issue a denial of payment within 30 days after receiving the bill.

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Basic Coverage Requirements—Non-Emergency

- More Specifically: Non-Emergency Services by an Out-of-Network Provider at an In-Network Facility
- Need not be covered, but if covered then rules apply:
  - Plan must have same cost-sharing requirements for both in-network and out-of-network services.
  - Plan must calculate out-of-network cost-sharing in the same way as for emergency services (state law or median contracted rate).
  - Plan must apply any cost-sharing amounts to both in-network deductibles and in-network out-of-pocket maximums.
  - Plan must make its initial payment or issue a denial of payment within 30 days after receiving the bill.

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Basic Coverage Requirements—Air Ambulance

- Need not be covered, but if covered then rules apply:
  - Plan must have same cost-sharing requirements for both in-network and out-of-network services.
  - Plan must use the in-network rates to calculate cost-sharing amounts for both in-network and out-of-network services.
  - Plan must apply any cost-sharing amounts to both in-network deductibles and in-network out-of-pocket maximums.
  - Plan must make its initial payment or issue a denial of payment within 30 days after receiving the bill.

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Balance Billing Prohibitions

- General Rule: For the above services, provider is not permitted to balance bill.
- Exception: With respect to non-emergency services performed by out-of-network provider at in-network facility, may balance bill for ancillary services with prior notice and consent.
  - Ancillary Services: Anesthesiology, pathology, radiology, neonatology; diagnostic services (radiology & laboratory); services by assistant surgeons, hospitalists, intensivists; services by out-of-network providers if no in-network providers are available.
  - Notice & Consent: Notice at least 72 hours in advance, or at the time appointment is made; notice to be available in 15 most common languages in geographic region; content requirements include good faith estimate of charges.

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Balance Billing Prohibitions (cont'd)

- Enforcement
  - State may enforce compliance with balance billing provisions
  - State may notify HHS, DOL, or IRS as applicable
  - HHS to have a process for receiving consumer complaints
  - DOL to have a process for
    - Receiving complaints from members
    - Receiving complaints from states or HHS
    - Investigating and enforcing in coordination with HHS

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Independent Dispute Resolution (IDR) Process

- Within 30 days of receipt of bill, plan sends initial payment or denial of payment.
- Provider has 30 days to initiate “open negotiation” period, which lasts 30 days.
- If period expires without agreement, parties have 4 days to request IDR.
- Parties have 3 days to select IDR entity.
  - If they fail to do so, DOL will select IDR entity within 3 days.
  - Both parties will pay an administrative fee to the DOL.
- 10 days after selection, provider and plan each submit an offer.
- 30 days after selection, IDR entity selects one of the offers.

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Independent Dispute Resolution (IDR) Process (cont'd)

- IDR entity must consider:
  - Median payment for similar services in same geographic region
  - Level of training, experience, and quality of provider or facility
  - Market share held by plan or issuer
  - Acuity and complexity of patient
  - Teaching status and scope of services offered by facility
  - Efforts made by provider or facility to enter into network agreement
- IDR entity must not consider:
  - Usual and customary charges
  - Billed amount that would otherwise apply
  - Rates of public payors (Medicare, Medicaid, TRICARE, etc.)

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Independent Dispute Resolution (IDR) Process (cont'd)

- Once determination is made
  - Plan has 30 days to pay any additional amount to provider.
  - Party whose offer was not selected pays the IDR entity's fee.
  - 90-day suspension period begins.
    - Generally, same provider cannot request IDR process for same services and plan during the period.
    - However, if 30-day open negotiation period for another matter expires during the suspension period, then instead of having 4 days to request IDR, provider has 30 days after the end of the suspension period to request IDR.
- Information regarding IDR to be provided to DOL. DOL to make information available to public on a quarterly basis.

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Patient Protections—Continuity of Care

- Applies if member is a “continuing care patient” with an in-network provider or facility, and that network status terminates.
- Continuing Care Patient:
  - Undergoing treatment for a “serious and complex” condition;
  - Undergoing a course of institutional or inpatient care;
  - Scheduled for nonelective surgery or postoperative care for same;
  - Pregnant and undergoing a course of treatment for the pregnancy; or
  - Terminally ill and receiving treatment.

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Patient Protections—Continuity of Care (cont'd)

- Plan must:
  - At time of termination, notify continuing care patients of their right to elect transitional care during specified period.
  - Allow continuing care patient to elect transitional care for specified period.
  - "Transitional Care" means continuing coverage and benefits under the plan as if termination had not occurred.
  - "Specified Period" begins on the date notification is provided and ends on the earlier of (i) 90 days later or (ii) the date the individual is no longer a continuing care patient.

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Patient Protections—Other

3 Provisions. All the same as the ACA.

- Choice of Primary Care Provider
  - If plan requires member to have a PCP, plan must allow member to select any in-network primary care provider.
- Access to Pediatric Care
  - For minor members, plan must allow pediatricians to be designated PCPs.
- Access to OB/GYN Care
  - For female members, plan must allow OB/GYNs to be designated PCPs.
  - Plan cannot require referrals for OB/GYN care.

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Transparency Lite

- Plan ID Cards (electronic or physical)
  - In-network and out-of-network deductibles and out-of-pocket maximums
  - Telephone number and website for consumer assistance
- Price Comparison Tool
  - Available via telephone and internet
  - Tool for comparing amount of cost-sharing that the member would be responsible for paying to different providers for the same service
- Balance Billing Disclosure
  - Plan must inform members regarding balance billing prohibitions and how to contact state and federal authorities regarding violations.
  - Include information on public website and each explanation of benefits.

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Transparency Lite (cont'd)

- Provider Directories
  - Plan must verify directory information every 90 days, update with new information every 2 days.
  - Plan must respond to member queries (telephone, email, internet) regarding provider's network status within 1 business day and retain response for 2 years.
  - Plan must establish a database of network providers and their name, address, phone number, specialty, contact information, and list of facilities where provider is in-network.
  - Plan must not impose out-of-network cost-sharing if directory or response indicated provider was in-network as of relevant date.

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Transparency Lite (cont'd)

- Advance Explanation of Benefits
  - If member schedules services at least 3 days in advance, providers must ask member for plan information and must provide a good-faith estimate of charges to the plan (including billing codes)
  - Plan must provide Explanation of Benefits 1 day later (3 days later in some cases) that includes the following information:
    - Whether provider is in-network or out-of-network;
    - Good-faith estimate of the total cost, amounts to be paid by plan and member, and where member stands with respect to deductible and out-of-pocket maximum;
    - Medical management requirements (pre-authorization, step therapy, etc.); and
    - Disclaimer.

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HEALTH PLANS
Transparency and Compliance

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No Gag Clauses

- Plans and providers cannot enter into contracts with:
  - Gag clauses on price and quality information
  - Prohibitions on the sharing of de-identified claims data for each enrollee on a per claim basis, including:
    - Allowed amount
    - Provider information, including name and clinical designation
    - Service Codes
- The Act specifically provides the information can be shared with business associates, but existing privacy rules continue to apply.
- Annual plan/issuer attestation required.
- Effective Date: Upon enactment.

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Mental Health Benefits

- Requires plan to analyze compliance with MHPAEA's rules on nonquantitative treatment limitations and to provide that analysis upon request to the secretaries of HHS, DOL, and Treasury.
  - Request can be made within 45 days after enactment.
- Secretaries must collect the analyses from at least 20 plans per year.
  - If the plan is found to be noncompliant, it will have 45 days to implement a corrective action plan or participants will be notified.
- Secretaries will publish guidance documents/complaint process to strengthen compliance with the rules on nonquantitative treatment limitations.

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Reporting on Pharmacy Benefits and Drug Costs

- Plans to report annually to the Secretaries of HHS, DOL, and the Treasury detailed information regarding:
  - Plan information (plan year, number of participants, etc.)
  - Plan spending (hospital, primary care, and prescription drugs),
  - Participant premiums, and
  - Any manufacturer rebates received by the plan and the corresponding impact, if any, on premiums.
- First report due one year after enactment.
- Subsequent report due by June 1 each year.

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Disclosure of Broker Compensation

- Brokers and consultants to disclose to plans—at the time of contracting—any direct or indirect compensation (if $1,000 or more) that they will receive as a result of their services.
- Failure to do so will mean the compensation is unreasonable.
- Effective Date: One year after enactment.

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OTHER WELFARE PLANS

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Health FSAs

- Grace Period
  - General Rule: Grace Period can last up to 2.5 months after the end of the plan year.
  - CAA: For plan years ending in 2020 and 2021, Grace Period can last up to 12 months after the end of the plan year.
- Carryover
  - General Rule: Can carry over up to $550 of unused funds from one plan year to the next.
  - CAA: For plan years ending in 2020 and 2021, can carry over "any" unused funds, subject to "rules similar to the rules applicable to health flexible spending arrangements."

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Health FSAs (cont'd)

- Spend-Down
  - General Rule: Spend-down provisions not permitted. Expenses incurred after participation ends cannot be reimbursed (subject to COBRA).
  - CAA: For plan years ending in 2020 and 2021, expenses incurred after participation ends but before the end of the plan year are reimbursable (even without COBRA), subject to "rules similar to the rules applicable to dependent care flexible spending arrangements."
- Change of Election
  - General Rule: Elections may be changed only for specified "life events."
  - CAA: For plan years ending in 2021, elections may be changed without regard to such "life events."

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Dependent Care FSAs

- Grace Period
  - General Rule: Grace Period can last up to 2.5 months after the end of the plan year.
  - CAA Rule: For plan years ending in 2020 and 2021, Grace Period can last up to 12 months after the end of the plan year.
- Carryover
  - General Rule: Carryovers not permitted.
  - CAA: For plan years ending in 2020 and 2021, can carry over "any" unused funds, subject to "rules similar to the rules applicable to health flexible spending arrangements."

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Dependent Care FSAs (cont'd)

- Covered Children
  - General Rule: May be used to pay for care for children under age 13.
  - CAA: May be used to pay for care for children under age 14, but only if (i) the employee was enrolled in the DCFSA for the last plan year whose enrollment period ended on or before 1/31/20 and (ii) the child turned 13 during such plan year (or during the following plan year, if the employee had a positive balance at the end of the previous plan year).
- Change of Election
  - General Rule: Elections may be changed only for specified "life events."
  - CAA: For plan years ending in 2021, elections may be changed without regard to such "life events."

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All FSAs

- Plan Amendments
  - Timing: Must be adopted no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective. (So for a calendar-year plan, amendments effective in 2020 may be made any time during 2021.)
  - Operations: Plan must be operated consistent with the terms of the amendment between the effective date and the signature date.

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Educational Assistance Programs

- These Are All Different:
  - Scholarships and Fellowship Grants under Code Section 117
  - *Educational Assistance Programs under Code Section 127*
  - Working Condition Fringe Benefits under Code Section 132
  - Tuition Remission under Code Section 170
- The CAA only made changes to *Educational Assistance Programs*

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Educational Assistance Programs (cont'd)

- General Rules:
  - Maximum Payment of $5250 per calendar year.
  - Must be for current or former employees only (not spouses or dependents).
  - Must not discriminate in favor of highly compensated employees.
  - May cover tuition, books, and fees, but not meals, lodging, or transportation.
- CAA:
  - May also cover "qualified student loans," if payment from employer to employee or lender is made on or before **12/31/25**.

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Educational Assistance Programs (cont'd)

- What is a "qualified student loan"?
  - Loans can cover tuition, fees, room and board.
  - Student must be enrolled at least half-time—must carry at least 50% of the normal full-time course load.
  - Courses must be leading to a degree, certificate, or other recognized education credential.
  - Courses must have been taken at an accredited post-secondary school.

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RETIREMENT PLANS

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Partial Plan Termination Relief

General Rule

- Upon a “partial termination” of a qualified retirement plan, affected participants must be fully vested.
- Under IRS guidance, there is a rebuttable presumption that a partial termination has occurred if there is a 20% or greater annual turnover rate among plan participants, due to employer-initiated severances.
- Turnover rate is generally (but not always) evaluated on a plan-year basis.

  Example:

  In the 2019 plan year, 13 participants were involuntarily terminated, of a total of 61 participants. 13/61 = 21.3%, so there is a rebuttable presumption of a partial termination.

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Partial Plan Termination Relief

COVID-19 Dilemma

Many employers temporarily reduced the size of their workforces due to COVID-19, and might have incurred partial terminations under the 20% annual turnover standard, even if they hired new employees as the economy rebounded as 2020 progressed.

CAA Relief

A plan will not be treated as having incurred a partial termination for a plan year which includes the period of March 13, 2020 to March 31, 2021, if the number of active participants covered by the plan on March 31, 2021 is at least 80% of the number of active participants covered on March 13, 2020.

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Money Purchase Plan Coronavirus Distributions

- The CARES Act permitted in-service distributions of up to $100,000 from retirement plans for individuals impacted by the coronavirus, and exempted coronavirus distributions from the 10% tax on early distributions.
- However, the CARES Act did not permit in-service distributions from money purchase plans before they are otherwise available under applicable law.
- CAA retroactively amends the CARES Act to clarify that coronavirus distributions from money purchase plans were permissible. (CARES Act coronavirus distributions of all types ceased to be available as of December 30, 2020.)

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Retirement Plan Disaster Relief Provisions (Non-COVID)

- CAA provides the following retirement plan disaster relief provisions:
  - Tax-favored withdrawals
  - Increase in loan limit and extension of repayment periods
  - Recontributions of home purchase withdrawals
- Similar in structure to CARES Act COVID withdrawal and loan provisions.

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Retirement Plan Disaster Relief Provisions (Non-COVID)

Tax-Favored Withdrawals

- "Qualified Disaster Distribution"
  - Made on or after the first day of the incident period of a qualified disaster and before June 25, 2021 (180 days after date of enactment of CAA).
  - Made to an individual whose principal place of abode during the incident period is located in the qualified disaster area and who sustained an economic loss by reason of the qualified disaster.
- "Qualified Disaster Area"
  - Area with respect to which a major disaster is declared by the President under Section 401 of the Stafford Act, between January 1, 2020 and February 25, 2021 (60 days after date of enactment of CAA) and incident period begins between December 28, 2019 and December 27, 2020 (date of enactment of CAA).
  - Disaster not related to COVID.

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Retirement Plan Disaster Relief Provisions (Non-COVID)

Tax-Favored Withdrawals

- Permits in-service withdrawal from DC plans even when not otherwise permitted.
- Not an eligible rollover distribution; no 20% mandatory federal tax withholding.
- 10% early distribution tax waived.
- $100,000 per qualified disaster.
- May repay the distribution to an eligible plan within 3 years.
- Income inclusion spread over 3 years unless participant elects otherwise.

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Retirement Plan Disaster Relief Provisions (Non-COVID)

Loan Provisions

Qualified Individual

- Principal place of abode during the incident period is located in a qualified disaster area; and
- Sustained economic loss due to the qualified disaster.

Increase in Loan Limits

- Lesser of 100% of vested account balance or $100,000 (double the usual limits).
- Loan made to a "qualified individual" between December 27, 2020 and June 25, 2021 (180 days after date of enactment of CAA).

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Retirement Plan Disaster Relief Provisions (Non-COVID)

Loan Provisions

Delay of Repayment

- Applies to a qualified individual with outstanding loan on or after the first day of the incident period.
- Applies to loan repayments due beginning on the first day of the incident period and ending 180 days after the last day of the incident period.
- Repayment may be delayed for 1 year (or if later, to June 25, 2021 – 180 days after date of enactment of CAA).
- Subsequent repayments must be increased for accrued interest, and the suspension period is disregarded for determining the maximum loan term.

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Retirement Plan Disaster Relief Provisions (Non-COVID)

Recontribution of Home Purchase Withdrawals

- Applies to individuals who received 401(k) or 403(b) hardship distributions, or IRA distributions qualifying for first-time homebuyer exemption from 10% early withdrawal tax.
- Distribution was intended for purchase or construction of a principal residence in a qualified disaster area, but was not used due to the qualified disaster.
- Distribution was received within 180 days before, and within 30 days after, the incident period.
- Relief: Amount withdrawn may be recontributed to an eligible retirement plan beginning on the first day of the incident period and ending June 25, 2021 (180 days after the date of enactment of the CAA).

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