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EMPLOYEE BENEFITS ADVISORY

Health and Welfare Plans and the Consolidated Appropriations Act

January 4, 2021

The Consolidated Appropriations Act, 2021 (the Act), signed by the president on December 27, 2020, provides numerous updates for employee benefit plans. This Client Advisory will focus on the key health and welfare benefit changes, and topics are organized in effective-date order.

Flexibility for Flexible Spending Accounts

The COVID-19 pandemic created a great deal of uncertainty for plan sponsors and employees who set their benefit elections during open enrollment in late 2019 for the 2020 plan year. Although the open enrollment period for the 2021 plan year has already passed, employers can elect to provide more flexibility for participants to use unused balances (including accounts left during plan years that ended in 2020). Note that these options are voluntary—if elected, employers will want to notify participants of their ability to use these new rules (and amend their cafeteria plans by the end of the 2022 plan year to reflect any changes):

1. Participants may carry over any unused amounts or contributions in their health flexible spending accounts (HFSAs) and dependent care flexible spending accounts (DCFSAs) from the plan year ending in 2020 to the plan year ending in 2021. Participants can carry over unused account balances again from the plan year ending in 2021 to the plan year ending in 2022.
2. Employers can extend grace periods for the plan years ending in 2020 or 2021 for 12 months after the end of each of those years.
3. Employers can amend HFSAs to allow employees who stop participating during 2020 or 2021 to continue receiving reimbursements from unused amounts through the end of the year in which the employees' participation ends. (This already is allowed for DCFSAs.)
4. Employers can allow a participant to carry forward DCFSA balances for dependents who aged out of eligibility during the pandemic.


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5. Employers can allow employees to make prospective election changes to FSAs at any time (without the need for any change in status) for the plan year ending in 2021.

Before implementing any of these changes, employers should make sure that their plan administrators can accommodate any options chosen.

Temporary Full Deduction for Business Meals

For expenses paid or incurred in 2021 and 2022, the Act will allow a full deduction (instead of the current 50% deduction) for food or beverage expenses for business meals provided by a restaurant.

Exclusion of Employer Payments for Student Loans

The CARES Act expanded the definition of education assistance under Code Section 127 to include an employer's payment (whether paid to an employee or a lender) of principal or interest before January 1, 2021, on any qualified education loan incurred by the employee for the employee's education. This Act extends this provision for an additional five years. Note that this option is voluntary, would still be limited to the maximum aggregate annual exclusion of $5,250, and would need to be included in an amendment to the employer's written education assistance plan.

Transparency and Patient Protections

The Act provides additional requirements for plans that impose nonquantitative treatment limitations on mental health or substance use disorder benefits. Under the Act, the plan or insurer must perform and document a comparative analysis of the design and application of these limitations. Beginning 45 days after enactment of the Act, plans and insurers must make these reports available to state or federal authorities, upon request. If a federal agency determines that the limitations do not comply with the applicable parity requirements, the plan or insurer must specify the corrective actions that it will take. If the plan or insurer remains out of compliance, participants must be notified of the noncompliance.

The Act also prohibits the use of "gag clauses" regarding price or quality information. In particular, plans and insurers may not enter into agreements with providers, third-party administrators, or other service providers to directly or indirectly restrict the plan or insurer from:

- Furnishing provider-specific cost or quality of care information to referring providers, plan sponsors, participants, or beneficiaries
- Electronically accessing de-identified claims information for a participant on request and consistent with HIPAA, GINA, and the ADA
- Sharing this information with business associates

These prohibitions are subject to "reasonable restrictions" a provider imposes on disclosure. No effective date is given for this new requirement.

Brokers and consultants to health plans also will be required to disclose service provider compensation if they expect to receive at least $1,000 in direct or indirect compensation for providing such services. This requirement is an expansion of the ERISA Section 408(b)(2) fee disclosure rules. These rules will apply one year after the Act's enactment.

By the first anniversary of the enactment of the Act, and each year thereafter, a plan or insurer is required to provide a report to Health and Human Services, the Department of Labor, and Treasury Department with information regarding specific pharmacy benefit and drug costs.

Surprise! The "No Surprises Act"

The Act also includes several provisions aimed at curbing surprise billing. These requirements apply for plan years beginning on or after January 1, 2022, and apply to all group health plans, including self-insured plans, and to nonfederal governmental and church plans.

- ***Emergency Room Services:*** Group health plans that cover emergency room services in a hospital or independent freestanding emergency department must cover those services:
  - Without requiring preauthorization determinations
  - Regardless of whether a health provider that delivers the services is a participating provider in the plan's network or the emergency facility
  - If the services are provided by out-of-network providers:
    - No preauthorization requirements or other limitation on coverage will be imposed that is more restrictive than the requirements that apply to emergency services received from participating providers.
    - The cost-sharing requirement cannot be greater than those for services provided by in-network providers.
    - The cost-sharing requirement must be calculated as if the total amount that would have been charged for those services by the participating provider were equal to the "recognized amount" for such services, plan, and year.
    - The plan or insurer must send the provider, within 30 days of receiving the provider's bill for services, an initial payment or notice that is denying payment and then must pay the remainder of the bill (the "out-of-network rate" minus the cost-sharing) consistent with certain timing rules.
    - Any cost-sharing payments made by the participant with respect to the emergency services must be counted toward any in-network deductible or out-of-pocket maximums.
  - Without regard to any other term or condition of coverage (other than coordination of benefits, exclusions, waiting periods, and cost-sharing)

In addition, the hospital, independent freestanding emergency department, or out-of-network provider cannot bill or hold a participant liable for any amount greater than the cost-sharing requirement.

- **Air Ambulance Services from Nonparticipating Providers:** Similar rules apply, as listed above.
- ***Non-emergency Services Performed by Nonparticipating Providers at Participating Facilities:*** Similar rules apply, as listed above, but only if the provider has not met the notice and consent criteria listed in the Act with respect to a visit. If the provider has met the notice and consent criteria, the provider can still bill the participant for the balance of the amount it wants to charge (other than for "ancillary services"). The notice (available in the 15 most common languages in the geographic region of the

facility) must be provided at least 72 hours before the date the participant is scheduled to receive the items or services and state that consent to receive those services from the nonparticipating provider is optional and the participant may seek care from a participating provider. The notice must provide a good-faith estimated amount that the provider may charge the participant for the services and meet other requirements.

The Act also includes open negotiation and independent dispute resolution procedures for use by plans, insurers, and nonparticipating providers to determine the amount that will be paid for a provided service.

The Act also requires, effective for plan years beginning on or after January 1, 2022:

- ***Additional Disclosures on Identification Cards:*** The Act requires plan-related identification cards to provide deductibles and out-of-pocket maximum limits applicable to the plan or coverage, and a telephone number and website address through which participants can obtain plan-related information.
- ***Advance Health Plan Estimates:*** If a plan or insurer receives a provider's notice regarding a participant's scheduled service, the plan or insurer must furnish the participant a notice (generally within one business day of receiving the provider's notice) that provides certain information, including whether the provider is a participating provider for the scheduled service and, if so, the contracted rate for the service based on relevant billing and diagnostic codes, a good-faith estimate of how much the plan will pay for the scheduled services, and any prior authorization or other case management requirements imposed by the plan.
- ***Continuity of Coverage:*** If a health provider is removed from a plan's network due to the end of a network contract, the plan or insurer will be required to timely notify plan participants who were receiving care from the provider that the provider is no longer part of the plan's network and that the participant has the right to continue receiving transitional care from the provider. If participants inform the plan that they need transitional care, the plan must allow the participants to elect to continue receiving plan-covered benefits under the same terms and conditions that would have applied had the provider not been terminated from the network and as continuing care patients for up to a 90-day period.
- ***Maintenance of Health Plan Price Comparison Tool:*** Plans and insurers must provide price comparison tools by telephone and through the plans' websites, allowing participants to compare their portion of cost-sharing under the plan for particular services and items for the plan year.
- ***Provider Directory Maintenance:*** Plans and insurers must set up a process to verify and update their provider directory information at least every 90 days, to provide responses to inquiries from the plan or insurer regarding whether providers or facilities are participating generally within one day, and to maintain a database of providers on the plan's or insurer's public website. If a participant receives incorrect, inaccurate, or out-of-date information regarding coverage of a provider or facility, the plan must impose the cost sharing amount, deductible, or out-of-pocket maximum it would have applied if it had been provided by a participating provider or facility.
- **Additional Disclosures of Patient Protections:** Plans and insurers also must make publicly available, post on a public website, and include in each Explanation of Benefits specific language regarding the requirements and prohibitions under the Act.

These new requirements constitute the most significant legislation since the Affordable Care Act and impose significant disclosures and reporting requirements (contemporaneously with the new cost-transparency requirements that will be the subject of an upcoming Client Advisory).

Questions

For any questions about how these new rules will apply to benefit plans, please contact a member the Sherman & Howard Employee Benefits Group.