CONSOLIDATED APPROPRIATIONS ACT OF 2021: SUMMARY OVERVIEW OF BENEFITS PROVISIONS

OVERVIEW

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act of 2021, which includes COVID-19 relief legislation. In addition to approximately $900 billion in stimulus spending, the legislation includes various benefits-related provisions, including (but not limited to):

- Extensions for the Families First Coronavirus Response Act (FFCRA) leave and tax credits;
- Temporary extension of healthcare FSA and dependent care FSA (DCAP) grace period and carryover provisions, and mid-year election change flexibility;
- An extension of student loan repayment relief;
- A new federal prohibition against certain surprise billing practices;
- Price transparency requirements which prohibit certain information from being withheld from third parties and require plans and issuers to file reports with the federal government; and
- Various provisions affecting retirement plan administration.

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This resource provides a high-level summary of the provisions impacting benefits administration.

FFCRA: LEAVE AND TAX CREDITS

The new law allows employers covered by the FFCRA (those with fewer than 500 employees) to extend the time they can offer emergency paid sick leave (EPSL) or expanded FMLA (EFMLA) to employees to March 31, 2021 (a three-month extension from the original expiration of December 31, 2020). If they do, then they can apply for the tax credits available under the FFCRA for leave granted under the extension.

Importantly, employers are not required to provide EPSL or EFMLA past the original expiration; however, if they do provide such paid leave voluntarily, employers can utilize the FFCRA tax credit until March 31, 2021. Further, the law does not appear to provide any additional leave for employees, just additional time during which employers may grant that leave if any is still available to the employee.

> **Employer Action:** Since FFCRA tax credits cannot be claimed for employees who have already exhausted their FFCRA leave, employers should consider already-exhausted FFCRA leave when providing any voluntary FFCRA leave through March 31, 2021, if they intend to apply for tax credits. Additionally, employers should be mindful of any paid sick leave and paid family leave requirements under state and local laws, and as well as their own paid leave policies.

HEALTH AND WELFARE BENEFITS PROVISIONS

FSAs and DCAPs: Extended Grace Period and Carryover; Mid-year Election Changes

For plan years ending in 2020 and 2021, both FSAs and DCAPs are permitted to carry over any unused funds to the following plan year (DCAP sponsors are temporarily permitted to adopt carryover features, which are otherwise limited to FSAs). There is no reference to the $550 (as indexed) carryover cap currently applicable to FSAs and as such, there does not appear to be any maximum carryover amount limit. Similarly, the law allows for an extension of FSA and DCAP grace periods for a plan year ending in 2020 or 2021 to be extended to 12 months after the end of the plan year.

Further, employees who cease participating in an FSA during calendar year 2020 or 2021 (e.g., terminated and/or furloughed employees) can continue to receive reimbursements from unused benefits or contributions through the end of the plan year in which such participation ceased (including any grace period, such as one extended under this law). This provision resembles a DCAP spend-down and does not appear to require employees to elect COBRA coverage in order to take advantage of it.

In addition to these extensions, for plan years ending in 2021, plans can allow employees to change elections mid-year to prospectively modify the amount (but not in excess of any applicable dollar limitation) of their contributions to an FSA or DCAP without a change in status qualifying life event.

The above referenced changes are optional for employers. Plan documents will need to be amended to make these changes; however, the amendments can be retroactive, if (1) such amendment is adopted not later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective (e.g., calendar 2020 plan amendments must be adopted on or before December 31, 2021); and (2) the plan or arrangement is operated consistent with the terms of such amendment during the period beginning on the effective date of the amendment and ending on the date the amendment is adopted.

The law also provides that expenses for an employee's child continue to be eligible for reimbursement under a DCAP even when the child turns age 13 (the age a child normally ages out of eligibility for qualified expenses), provided that the regular enrollment period for the DCAP plan year at issue ended on or before January 31, 2020. This also goes for any unused balance rolling over to the next plan year, which means that unused balances carried over from 2020 can be used in 2021 for a child that turned 13 in 2020 and will turn 14 in 2021.

> **Employer Action:** Should an employer choose to implement the FSA and/or DCAP flexibilities, it should communicate with participants accordingly and amend plan documents as described above. Importantly, an employer who offers an HSA option should also consider how an FSA rollover or grace period impacts HSA eligibility and communicate with employees accordingly.

Surprise Billing

Effective January 1, 2022, the legislation protects people from large unexpected medical bills they may incur when obtaining emergency medical care from out-of-network providers (including air ambulance services). The law requires health plans or insurers to pay out-of-network providers for emergency care services provided to their insureds, without imposing increased cost sharing or pre-authorization requirements upon the insureds. This means insureds will be required to pay only the in-network cost-sharing amount when obtaining emergency medical care from out-of-network providers, to be determined by a formula established by HHS. Further, any cost sharing imposed upon the insureds for these services will be treated the same way they are treated when applied towards services provided by in-network providers (such as counting towards out-of-pocket maximums or in-network deductibles).

Insurers and plans can negotiate with the out-of-network providers on the price they will pay for the emergency services. The out-of-network providers would bill the plan or insurer for the services and the plan or insurer would have 30 days to either make an initial payment or deny the payment. The initial payment (or "qualifying payment") is an amount determined to be the median payment amount for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished. (HHS is charged with promulgating rules for determining qualifying payments by July 1, 2021.) Regardless of whether a payment is made or denied, the parties have 30 days to negotiate the price that the plan or insurer will ultimately pay for the item or service and, if that fails, the parties may also arbitrate. Once an arbitrator is agreed upon, then the arbitrator has 30 days to determine the price. The arbitrator cannot consider benchmark or government reimbursement rates when determining a price.

The prohibition against balance billing will not apply to providers who provide services to patients (that are not considered "ancillary" services) if:

- the patient receives an oral and written notice 72 hours in advance of the appointment for the service that explicitly states that the provider is out-of-network;
- consent to receive the service out-of-network is optional and the same service can be obtained by an in-network provider;
- the provider provides a good faith estimate of the amount that the patient will be charged for the service if they consent;
- the facility provides a list of any in-network providers who can provide the same service (if the out-of-network provider in question works out of an in-network facility); and
- the patient consents to the notice in writing and receives a copy of the signed consent.

For purposes of this law, "ancillary services" include: emergency medicine, anesthesiology, pathology, radiology and neonatology; items and services provided by assistant surgeons, hospitalists and intensivists; diagnostic services that are not exempted by rule; and items and services provided by non-participating providers if there are no participating providers at the same facility who can furnish such items or services.

Among other items of note, the law also imposes a requirement that all insurance ID cards include plan deductibles for both in- and out-of-network services, out-of-pocket maximums, and plan telephone number and web address. It further requires plans to provide, upon request of a participant or provider, an explanation of whether a particular provider or facility is in- or out-of-network for the service to be provided, the contract rate for that service, and whether that service can be obtained in-network.

States are charged with enforcing these provisions and they can impose additional obligations on out-of-network providers that go beyond those established by this law. If the states do not want to enforce these provisions, then HHS can do so.

> **Employer Action:** Employers should be aware that these developments are effective beginning January 1, 2022. As the effective date approaches, employers should confirm with applicable carriers and third-party administrators that the plan will operate in compliance with the new law.

Price Transparency

The law encourages price transparency by prohibiting health plans and insurers from entering into agreements with providers that prohibit the provision of provider-specific cost or quality of care information; electronic access to de-identified claims and encounter information for each enrollee in a plan; or the sharing of the above information/data with business associates in accordance with HIPAA standards.

Beginning one year after the law's passage, and every June 1 thereafter, group health plans and issuers must submit a very detailed report to the DOL and Department of the Treasury that includes, among other things: the number of enrollees in the plan; the plan year; the states in which they offer coverage; the top 50 brand drugs dispensed by pharmacies for claims under the plan and the total claims paid for each drug; the top 50 by total annual spending and the annual amount spent for each of those drugs; and total spending by the plan (broken down by types of cost, such as hospital and primary care, specialty care, provider and clinical service costs, prescription drugs, wellness and plan and enrollee spending on prescription drugs).

Additionally, for plan years beginning on or after January 1, 2022, plans and insurers must provide an advance explanation of benefits (EOB) for scheduled services or upon request. The EOB must include:

- Whether or not the provider or facility is in-network;
- The contracted rate for each item or service (if in-network), or description of how to obtain information for an in-network provider or facility (if out-of-network);
- A good faith estimate as received from the provider (or facility), including the amount the plan is responsible for paying and a good faith estimate of any cost sharing amounts;
- A good faith estimate of the amount the insured has incurred toward the deductible and out-of-pocket maximum;
- A disclaimer regarding any required medical management techniques (e.g., prior authorization); and
- A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, and is subject to change.

Further, plans and insurers must provide this EOB within three business days of receiving a request or notice that a service had been scheduled, if the service was scheduled for at least 10 business days after the notice. However, when the service is scheduled for less than 10 days after the notice, the plan must provide the EOB within one business day.

Employer Action: Employers should be aware of these developments. As the effective dates approach, employers should confirm with applicable carriers and third-party administrators that the plan will operate in compliance with the transparency requirements of the new law.

Student Loan Payment Extension

As provided through the CARES Act, employers can provide a student loan repayment benefit of $5,250 to employees tax-free through an education assistance program for 2020 (before January 1, 2021). Now, the new law has extended this benefit to payments made before January 1, 2026.

Employer Action: Employers should be aware of this benefit as the ability to provide such benefit is currently extended for five years. If interested in providing student loan repayment, employers must adopt a formal education assistance program.

Other Items Impacting Health and Welfare Benefits Administration

- If a network provider's contract is terminated while an insured is receiving care, the "continuing care patient" must receive a notice from the plan with instructions on how to elect transitional coverage. The coverage will continue to pay the continuing care expenses at the network rate for up to 90 days. The care must be inpatient care; a serious and complex condition; non-elective surgery and post-operative care; pregnancy; or a terminal illness.
- Any health insurer or group health plan that imposes non-quantitative treatment limitations (NQTLs) on mental health or substance use disorder benefits, must perform and document comparative analyses of the design and application of NQTLs. Additionally, beginning 45 days after the law's enactment, they must make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of HHS), upon request, the comparative analyses and certain other information. The departments will issue a guidance document with illustrative examples. If benefits match the benchmark (and the benchmark is in compliance), then the plan is in compliance.
- Health issuers and plans must make a price comparison tool available by January 1, 2022, and are required to regularly update the provider network directory. If an insured receives incorrect information from the directory, then services are covered at in-network rates. Plans are prohibited from contracting with providers who refuse to disclose cost information.
- At the time of contracting, brokers and consultants to plans must disclose any compensation (direct or indirect) they will receive due to services provided on behalf of the plan. This reflects an extension of ERISA's 408(b)(2) requirements to health plans.
- The Employer Tax Credit for employer provided paid family and medical leave is extended from December 31, 2020 to December 31, 2025.

RETIREMENT PROVISIONS

Partial Plan Termination Relief

The law provides relief from the requirement that employees be 100% vested in employer contributions should a partial plan termination occur. As background, when an employer terminates 20 percent or more of its workforce, it can trigger a partial plan termination (which would require the employer to vest their employees at 100%). The law states that a company will not trigger a partial plan termination during the period beginning March 31, 2020 and ending March 31, 2021 as long as on the latter date the plan has at least 80 percent of the active participants that were enrolled on the former date.

Employer Action: Employers should work with their service providers to determine whether they can and should take advantage of this relief. Distributions that have not yet been made to employees that terminated in 2020 may fall under this relief, and may allow the employer to apply a vesting schedule.

Disaster-Related Distributions and Loans

For recent FEMA-declared disasters, the law allows for hardship distribution and loan relief, similar to that which was provided under the CARES Act (i.e., up to $100,000 distribution or loan, penalty tax relief, and loan suspensions). Although this provision was not extended for COVID-19 (that guidance mostly ended December 31, 2020), it does apply to any federally declared disasters that occurred going back to January 1, 2020, and through 60 days after enactment of the law. Corresponding distributions can be made through 180 days after enactment.

The law also extends the CARES Act hardship distribution and loan relief to money purchase pension plans going back to when those provisions were passed. This provision was not extended, so it is retroactive in nature at this point, applying to any hardship distributions or loans that were taken through December 31, 2020.

> **Employer Action:** Employers should be aware of these developments. Money purchase pension plan sponsors can work with their service providers to extend the CARES Act hardship distribution and loan relief to plan participants. Any employers with employers in areas that experienced non-COVID, FEMA-declared disasters can provide this relief to participants as well.

Miscellaneous Retirement Plan Relief

The law also addresses a few other retirement plan issues. Specifically, the law provides:

- Defined benefit plan sponsors to cancel any qualified future transfer of the assets used to pay future retiree health/life insurance. The unused funds would be returned to the health/life plan.
- In-Service Distributions for employees working in the building and construction industry after age 55; and
- A requirement for the DOL to report on the impact of the electronic disclosure regulations that were implemented in 2020.

SUMMARY

As highlighted above, the law includes several benefits-related provisions that will affect how group health and retirement plans are administered. We expect the agencies involved to provide guidance on these changes in the coming months. Employer plan sponsors should work with their vendors and service providers to achieve any necessary changes. We will continue to provide information on any additional guidance as it comes.