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Consolidated Appropriations Act, 2021 Makes Major Employee Benefit Changes

January 7, 2021

On December 27, 2020, the Consolidated Appropriations Act, 2021 (the "CAA") was signed into law. The CAA is best known for providing many Americans with a $600 stimulus check due to the ongoing pandemic. But the CAA is over 5,000 pages long, and many of those pages include major changes to group health plans ("health plans"), health and dependent care flexible spending arrangements (collectively, "FSAs"), educational assistance programs, and retirement plans. This Client Alert summarizes the CAA's major provisions that affect employee benefit plans and provides action steps for employers to implement these changes.

Dependent Care and Health FSAs

These changes are optional, so an employer is not required to adopt them. If utilized, amendments will be required.

Changes That Can Apply to Health FSAs Only

Post-Termination Health FSA Reimbursements

A health FSA may allow an employee who ceases participating in the FSA during 2020 or 2021 to receive reimbursements from unused contributions through the end of the plan year in which such participation ceased (including any grace period).

Changes That Can Apply to Dependent Care FSAs Only

Special Carry Forward Rules for Dependent Care FSAs

First, dependent care FSA participants normally cannot carry over unused amounts from one plan year to the next. The CAA temporarily permits dependent care FSAs to provide carryovers.

Second, the normal rule is that a dependent care FSA can be used for expenses related to children under 13. Because of the pandemic, the CAA allows participants to receive dependent care reimbursements for qualifying children who turned age 13 during the COVID-19 pandemic. The CAA also allows participants with remaining dependent care FSA contributions to use those amounts in the following plan year until the child turns age 14.

Changes That Can Apply to Both Dependent Care and Health FSAs

Carryovers

The CAA temporarily permits dependent care and health FSAs to allow any unused 2020 dollars to be used in 2021 and any unused 2021 dollars to be used in 2022.

Extended Grace Periods

A dependent care or health FSA may have a 12-month grace period for the 2020 and 2021 plan years. The extended grace period provides participants a longer period of time to incur claims that may be reimbursed from an FSA for the applicable plan year.

Changing FSA Election Amounts

For plan years ending in 2021, a dependent care or health FSA may allow an employee to prospectively change, for any reason, the amount the employee elected to contribute to the FSA.

New Health Plan Contracting Requirements

Eliminating Contractual "Gag Clauses"

Effective December 28, 2021, a health plan cannot enter into an agreement with a health care provider, network, third-party administrator, or other service provider offering access to a network of providers if that contract directly or indirectly restricts the plan from providing specified information. For example, the contract cannot prohibit a plan from (i) providing provider-specific cost or quality care information or data to the plan sponsor or participants, (ii) electronically accessing de-identified claims information for each participant, including per-claim financial information, provider information, and service codes, or (iii) sharing such data with a business associate. A health plan must annually submit an attestation to the federal government that the plan complies with these rules.

New Disclosures of Direct and Indirect Broker and Consultant Compensation

Federal law requires plan fiduciaries to ensure that a plan does not pay more than reasonable compensation for services necessary to operate it. Effective December 28, 2021, consultants and brokers must disclose in writing specific detailed information relating to their services and direct and indirect compensation. These rules are modeled after the rules that have been in place for several years for retirement plan service providers.

Health Plan Provisions

We expect insurance companies and third-party administrators to help address the following changes to plan design and operations. However, because an employer with a self-funded health plan is ultimately obligated to ensure the plan's compliance with these changes, all documents from the plan's service providers should be carefully reviewed.

Surprise Billing Limitations and Related Requirements

Surprise billing occurs when a patient goes to an out-of-network provider. The CAA addresses surprise billing for emergency, non-emergency, and air ambulance services. Beginning January 1, 2022, the CAA establishes cost-sharing requirements and the amounts and time periods by which a plan must pay providers. We expect additional guidance to help health plans implement these new limitations on surprise billing, special air ambulance reporting obligations, and an expansion of a plan's external review process to address surprise billing and air-ambulance claims.

Independent Dispute Resolution Process for Determining Out-of-Network Rates

By December 28, 2021, federal agencies must issue regulations to implement a new independent dispute resolution process, which a health plan and certain out-of-network providers (including air ambulances) will use to determine the amount payable for services when the plan and provider cannot reach an agreement. Beginning in 2022, the Secretary of Labor will make available information regarding the dispute resolutions on a public website.

In-Network and Out-of-Network Cost Transparency on ID Cards

Beginning January 1, 2022, health plans must include the following information on any physical or electronic plan or insurance identification card issued to a participant: any deductible, any out-of-pocket maximum limitations, and a telephone number and website where participants may seek consumer assistance information, such as information on in-network providers.

Advanced Explanation of Benefits

Beginning January 1, 2022, a health plan that receives a notification from a provider regarding a participant's scheduled service must generally provide the participant, within one business day, a notification that includes specific information, such as whether the provider is in-network (and, if so, the contracted rate for the item of service), a good faith estimate of the amounts the plan and participant are each responsible for paying, a good faith estimate of the amount the participant has incurred toward meeting the plan's deductible and out-of-pocket maximums, and information relating to medical management techniques.

Ensuring Continuity of Care for Serious and Complex Conditions

Effective January 1, 2022, health plans must satisfy new continuity of care requirements for patients who are receiving specified types of care if an in-network provider terminates its relationship with a plan or the plan's benefits with respect to a provider are terminated. Among other things, the plan must notify certain patients of the provider's termination and the right to elect to receive transition care from the provider under the same terms and conditions that would have applied had the termination not occurred. The patient may elect to continue receiving care from the provider for a specified period of time as if the termination had not occurred.

Price Comparison Tools

Effective January 1, 2022, health plans must offer price comparison guidance by telephone and an Internet price comparison tool that allows participants to compare the amount of cost-sharing that the

individual would be responsible for paying under the plan for a specific item or service by an in-network provider.

Provider Directories

Beginning January 1, 2022, health plans must establish a process to verify and update provider directory information at least every 90 days. The plan must respond to telephonic requests regarding whether a health care provider or facility is in-network no later than one business day and retain communications for at least two years. A plan must also maintain a public website that contains a list of in-network providers/facilities with directory information. Any print directories must include a specified notice.

Reliance on Provider Information

In general, beginning January 1, 2022, if a participant is informed by a plan that a provider/facility is in-network but it is actually out-of-network, the participant can be charged only the in-network cost-sharing and deductible amounts for the furnished item or service.

Balance Billing Disclosures

Beginning January 1, 2022, a health plan must make publicly available, post on the plan's public website (which likely will need to be established and maintained under a contract with the insurer or third-party administrator), and include on each explanation of benefits certain information in plain language, such as a description regarding the prohibition on balance billing in certain circumstances and contact information for applicable state and federal regulators.

Mental Health and Substance User Disorder Benefits

Health plans must perform and document a comparative analysis of the design and application of the plan's mental health, substance use disorder, and medical/surgery nonquantitative treatment limitations and, by February 10, 2021, be able to make available to federal regulators, upon request, the comparative analysis. Regulators will likely request the analysis based on complaints that a plan is not complying with the mental health parity rules.

Reporting on Health Care and Pharmacy Benefits and Drug Costs

By December 28, 2021, and not later than June 1 each year thereafter, a health plan must report detailed information to federal regulators relating to its benefits and prescription drug claims and costs.

Employer Payments of Student Loans

The CAA extends the time period to January 1, 2026 (from January 1, 2021) for employers to use an educational assistance program to make certain tax-free payments of employees' qualifying education loans.

Retirement Plan Provisions

The CAA provides several forms of pandemic and disaster relief for retirement plans, as well as a few technical corrections, including:

- *Deductibility of Retirement Plan contributions.* The CAA affirms that retirement plan contributions are deductible even if they are financed by Paycheck Protection Program ("PPP") loan proceeds.

- *Partial Plan Termination Relief.* The CAA permits a company to avoid the 100% vesting requirement associated with a partial plan termination if the plan covers at least 80% as many participants on March 31, 2021 as were covered by the plan on March 13, 2020.

- *Section 420 Transfers.* Employers that had elected to make a "qualified future transfer" under Section 420(f) of the Internal Revenue Code may elect, by December 31, 2021, to terminate the transfer and revert the unused funds to the defined benefit plan, with certain conditional responsibilities spelled out in the CAA.

- *Disaster Relief.* The CAA provides optional relief for non-coronavirus-related disasters (such as storms or fires) that occur between January 1, 2020 and February 25, 2021. The relief allows affected participants in declared disaster areas to take qualified distributions of up to $100,000 in aggregate from 401(k), 403(b), 457(b), or money purchase plans without tax penalties and with the option to repay the distributed amounts. Larger loan limits and loan payment delays also are permissible.

Next Steps

The most immediate issue is to take steps to confirm that the health plan's third-party administrator or insurer is preparing and will make available the analysis of the plan's nonquantitative treatment limitations by the February deadline.

Next, employers should decide whether to implement any of the FSA changes and prepare and distribute employee communications (and ultimately plan amendments).

The new broker and consultant disclosures, as well as the elimination of "gag clauses," become effective in December 2021.

- Employers should review and amend their broker and consultant contracts to ensure they timely receive the required information.
- Employers should also establish a fiduciary process for reviewing the broker and consultant disclosures and documenting the review.
- Employers should review and amend their service provider and business associate agreements to eliminate "gag clauses."
- Any amendment a broker, consultant, third-party administrator, or other vendor provides should be closely examined to ensure it complies with the CAA.

Many of the health plan-related changes take effect January 1, 2022 and will require third-party administrators and insurers to provide new services and health plan provisions. We anticipate that later this year, insurers and third-party administrators will begin providing amendments to:

- service provider agreements,
- health plan documents,
- summary plan descriptions, and
- summaries of benefits and coverage.

Employers should carefully review those amendments to ensure they include all the provisions required by the CAA and, with respect to contractual amendments, properly allocate responsibilities (and liability).

If you laid off or severed a significant percentage of your employees in 2020, evaluate whether a partial plan termination occurred or can be avoided in your retirement plan prior to March 31, 2021. Employers wishing to take advantage of the other retirement plan relief provisions may need to adopt a plan amendment or take other affirmative action to qualify for relief.

If you have any questions about the CAA or how its changes impact your employee benefit plans, contact one of the members of the Kutak Rock Employee Benefits Practice Group.

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