IslerDare PC
Your workplace, our insight

Employee Benefits Update January 11, 2021

Key Implications of the Consolidated Appropriations Act, 2021 on Employee Benefit Plans

Executive Summary

On December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021 (the "CAA"). The CAA contains numerous payroll, retirement, and health and welfare provisions, many of which relate to COVID-19 relief. This newsletter highlights the following key features of the CAA:

- Payroll Relief
- Surprise Medical Billing and Health Coverage Transparency Rules Affecting Group Health Plans
- Enhanced Flexibility for Health and Dependent Care Flexible Spending Accounts
- Retirement Plan Provisions
- Extension of Tax Exemption for Student Loan Repayments

Of all the benefits-related changes in the CAA, the most immediately helpful may be the ones that affect flexible spending accounts, but the most sweeping ones affect group health plans and will require significant changes to plan documentation; updates to service agreements with your plan providers, administrators, and HIPAA business associates; and new disclosure and reporting obligations.

□–□–□–□–□–□–□–□–□–□–□–□–□–□–□–□–□–□–□

I. PAYROLL RELIEF

The CAA provides certain payroll-related relief to businesses and individuals, including the following:

- ***Expansion and Extension of Employee Retention Credit***. The CAA expands and extends the employee retention credit introduced as part of the CARES Act (previously discussed here), which provided certain eligible employers who were financially impacted by the COVID-19 pandemic with a refundable payroll tax credit for a percentage of "qualified wages". The credit is now available until July 1, 2021; the percentage of qualified wages eligible for the credit has increased from 50% to 70%; and the per employee limit on qualifying wages has increased to $10,000 per quarter (thereby increasing the payroll tax credit to $7,000 per employee per quarter). In addition, the definition of eligible qualifying employers has changed.

- ***Extension of Paid Sick and Family Leave Tax Credits***. The paid sick and family leave refundable tax credits enacted as part of the Families First Coronavirus Response Act (and previously discussed in our User's Guide) are extended for three additional months, through March 31, 2021, even though the corresponding emergency paid sick leave and expanded family and medical leave requirements expired on December 31, 2020.

- ***Extension of Deadline to Repay Deferred Payroll Taxes***. If an employer voluntarily deferred payment of their employees' share of Social Security taxes on applicable wages between September 1, 2020 and December 31, 2020, they now have until December 31, 2021 (not April 30, 2021) to have their affected employees pay the deferred taxes. The CAA also clarifies that penalties and interest will not begin to accrue on the deferred amounts until January 1, 2022.

II. SURPRISE MEDICAL BILLING AND TRANSPARENCY RULES AFFECTING GROUP HEALTH PLANS

The CAA includes numerous provisions intended to protect individuals from "surprise" medical bills from out-of-network providers or facilities, and to promote greater transparency about health care costs. These rules apply to fully-insured and self-insured group health plans alike, and are generally effective for plan years that begin on or after January 1, 2022. They will require significant revisions to plan documents, summary plan descriptions, claims procedures, and service agreements with your insurance companies, third-party administrators, pharmacy benefit managers, or consultants:

- ***Restrictions on Surprise Bills from Out-of-Network Providers***. Under the CAA, out-of-network providers will no longer be able to balance bill individuals who received specific non-emergency services at an in-network facility, unless (i) the out-of-network provider gives an advance notice to the individual about the provider's non-network status, along with an estimate of charges at least 72 hours in advance, ***and*** (ii) the individual consents. If both conditions are met, the out-of-network provider will still be able to balance bill. However, consent waivers cannot be requested by emergency medicine providers or certain other defined "ancillary" services offered at an in-network facility.

- ***Coverage of Emergency Services***. A group health plan must cover emergency services in a hospital emergency department or freestanding emergency department at the same level, regardless of whether the provider is in-network or out-of-network. In addition, the total allowable charges under the plan must be based on the median price allowed for in-network providers for a given procedure in the same geographic region, and all out-of-pocket amounts must count towards the plan participant's in-network deductible and out-of-pocket maximums in the same way as like charges from network providers.

- ***Air Ambulance Providers***. Coverage for air ambulance providers must be at the same level for in-network and out-of-network providers, and all out-of-pocket amounts must contribute toward the in-network deductible and out-of-pocket maximums in the same way as like charges from network providers.

- ***Prompt Payment and Dispute Resolution Processes***. The surprise billing rules governing emergency services, out-of-network providers at in-network facilities, and air ambulances charges also require a plan to make an initial payment (or notice of denial) within 30 days after a bill is transmitted, to engage in an open negotiation process, and to use an independent dispute resolution (IDR) process for negotiating and settling out-of-network claims. The IDR entity will consider the median in-network rate for the same service in the same geographic area but will not consider usual and customary or billed charges, or Medicare reimbursement rates, which are often used by self-funded group health plans to determine the allowable reimbursement under the plan. In order to encourage settlements, the party that initiated the IDR process may not request IDR with the same other party for 90 days following a determination.

- ***Continuity of Care Requirements.*** Group health plans must provide 90 days of continued in-network care if a provider leaves the network and a participant is undergoing treatment for a serious and complex condition, is pregnant, is receiving inpatient care, is scheduled for non-elective surgery, or is terminally ill. Notice of the departing provider must also be provided.

- ***Enhanced Disclosure and Transparency Requirements***. Group health plans and health insurance issuers must comply with the following new disclosure requirements aimed at providing more transparency to participants. These new requirements are part of a growing trend towards increased consumer transparency and disclosure of health care pricing, including comprehensive transparency regulations that were issued separately by the government in late Fall 2020, are scheduled to take effect for plan years beginning on or after January 1, 2022, and require group health plans to publicly disclose in-network provider negotiated rates as well as historical out-of-network allowed amounts and prescription drug pricing information. These separate transparency regulations, as well as the CAA changes, will require significant enhancements to service agreements with group health issuers and third-party or claims administrators:

    - Advanced Explanation of Benefits/Good Faith Estimates. Group health plans that receive a health care provider's good faith estimate of expected charges for a scheduled service must provide notice to the plan participant of this estimate promptly, after receiving the provider's estimate, in order to inform the plan participant of the expected cost and network status of the providers.

    - Provider Directories. Group health plans must provide to participants (i) an accurate directory of providers that is electronically and publicly available for patients, which is verified and updated every 90 days; and (ii) access to a system providing a 24-hour response to inquiries regarding a provider's network status.

- Enhanced Information on Insurance Cards. Group health plans must issue insurance cards that include additional information, such as deductibles, out-of-pocket limits, and consumer assistance contact information.

- Annual Reports on Prescription Drug Benefits. Within one year of the date of the CAA's enactment (i.e., by December 27, 2021), and annually thereafter by June 1st of each year, each group health plan must submit a detailed information report on the plan's prescription drug costs and benefits to the IRS, the DOL and HHS. Ultimately, HHS will aggregate and de-identify this information into publicly-available reports.

- Gag Clauses in Service Agreements and Annual Attestation of Compliance. Group health plans will be prohibited from entering into contract terms with network providers, third-party administrators, HIPAA business associates, or other service providers that would directly or indirectly restrict the plan from providing certain cost or quality-of-care information or data, electronically accessing de-identified claims information or data, or sharing this information. In addition, group health plans will be required to submit an annual attestation of compliance with these terms.

- Fee Disclosures. Health insurance brokers or consultants will be required to provide annual disclosures to group health plans of their direct and indirect compensation, similar to the annual fee disclosures already required by retirement plan providers.

- Disclosures of Mental Health Parity Analyses. Group health plans that impose non-quantitative limits on mental health or substance abuse treatment (such as fail-first or step-therapy protocols) must document comparative analyses of the design and application of these limits and, within 45 days of December 27, 2020, these analyses must be available to DOL, IRS or HHS upon request.

III. ENHANCED FLEXIBILITY FOR HEALTH AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The CAA loosens rules applicable to health and dependent care flexible spending accounts (FSAs) for 2021 and, in some cases, for 2022. These are permissible, not mandatory changes, but if you want to adopt some or all of them for your employees, you will need to amend your FSA plan documents by the end of the first calendar year following the plan year in which the changes take effect (*i.e.*, by December 31, 2022 for changes that take effect for a calendar year FSA plan in 2021). In addition, you will need to work with your FSA administrator to ensure that FSA operations are consistent with the terms of the amendment beginning on its effective date, and to be mindful of how these changes might impact employees who make elections to participate in high-deductible plans/health savings accounts in future years. The permissible changes to FSAs are summarized below:

- ***Mid-Year Election Changes Without Status Changes***. For plan years ending in 2021, FSAs may allow employees to make a prospective mid-year election change to modify their FSA contributions without a qualifying change in status.

- ***Health FSA Reimbursements***. Health FSAs may allow an employee who ceases participation during the 2020 or 2021 calendar year to continue to receive reimbursements from unused balances through the end of the plan year in which such participation ceased (including any grace period). Plan sponsors already have the ability to adopt similar provisions for dependent care FSAs.

- ***Carryovers of Unused Amounts***. Health and dependent care FSAs can allow unused amounts from a plan year ending in 2020 to be carried over to 2021, and unused amounts from a plan year ending in 2021 can be carried over to 2022, without any limitation or maximum on the carryover amount.

- ***Grace Period Extensions***. The grace period for a plan year ending in 2021 or 2022 may be extended to 12 months after the end of the plan year.

- ***Increase in Dependent Care Age***. Dependent care FSAs may extend the maximum age from 12 to 13 for eligible dependents who aged out of eligibility during the last plan year with a regular enrollment period ending on or before January 31, 2020, and may allow employees with unused balances to receive reimbursements for that child's care expenses for the remainder of this year.

IV. RETIREMENT PLAN PROVISIONS

The CAA provides additional relief to employer-sponsored retirement plans:

- Partial Plan Termination Relief. A tax-qualified retirement plan will not be treated as having a partial termination, and thus will not be required to fully vest all affected participants, during any plan year which includes the period beginning on March 13, 2020, and ending March 31, 2021, if the number of active participants covered by the plan on March 31, 2021 is at least 80% of the active participants covered by the plan on March 13, 2020. This provision is intended to help employers who may have laid off employees in response to the COVID-19 pandemic but who then re-hired them relatively quickly.

- Money Purchase Plan Coronavirus-Related Distributions. The CARES Act exception to the 10% early withdrawal tax for coronavirus-related in-service distributions now applies to coronavirus-related in-service distributions made from money purchase pension plans. This provision applies retroactively to coronavirus-related in-service distributions from money purchase pension plans made on and after March 27, 2020.

- Disaster-Related Distribution and Loan Relief (non-Coronavirus related). Participants that maintain a principal residence within a federal disaster area, which is declared during the period beginning January 1, 2020, and ending on February 25, 2021, may be able to take up to $100,000 from a qualified retirement plan without incurring an early-distribution penalty. Additionally, increased loan amounts and suspension of loan repayments of up to one year may be available to qualifying individuals affected by such disasters. Employers wishing to adopt these provisions will need to adopt corresponding plan amendments by the last day of the first plan year beginning on or after January 1, 2022 (*i.e.*, December 31, 2022 for calendar year non-governmental plans).

- In-Service Distributions. In very targeted relief, the permissible age for in-service distributions in building and construction multiemployer plans is lowered from age 59-½ to age 55 for certain employees in the building and construction industry.

V. EXTENSION OF TAX EXEMPTION FOR STUDENT LOAN REPAYMENTS

The CAA extends the temporary provision allowing employers' education assistance programs to repay qualified student loans through December 31, 2025, with the annual maximum nontaxable benefit remaining at $5,250.

□–□

To discuss the Consolidated Appropriations Act, 2021, or other employee benefits matters, please contact any member of our Employee Benefits and Executive Compensation Group below.

IslerDare PC

1945 Old Gallows Road
Suite 650
Vienna, VA 22182
(703) 748-2690

1111 East Main Street
Suite 1605
Richmond, VA 23219
(804) 489-5507

Andrea I. O'Brien
aobrien@islerdare.com

Vi D. Nguyen
vnguyen@islerdare.com

Jeanne Floyd
jfloyd@islerdare.com

Ashley Hedge
ahedge@islerdare.com