COMPLIANCE ALERT

EPIC Insurance Brokers & Consultants

Employee Benefits Changes Under the Consolidated Appropriations Act

February 1, 2021

QUICK FACTS

- Employers have additional flexibility in administering Health FSAs and DCAPs in 2020 and 2021
- The No Surprises Act is effective January 1, 2022. Additional rulemaking is coming midyear 2021.
- Many new disclosure requirements for insurers, plan sponsors and consultants, are coming later this year and in 2022.
- Final nondiscrimination requirements for providers are coming in 2021 to be effective in 2022.

On December 21, 2020, Congress passed the Consolidated Appropriations Act, 2021 (CAA) and President Trump signed it into law on December 27, 2020. The year-end appropriations bill provides ongoing relief and funds relating to the COVID-19 pandemic, including permissible changes to Flexible Spending Accounts (FSAs) and Dependent Care Assistance Programs (DCAPs, a balanced billing provision, and relaxed or amended several rules that affect employer-sponsored health and welfare plans. Below is a summary of the CAA's new rules and requirements that will impact health and welfare plans.

ADDITIONAL FLEXIBILITY FOR FLEXIBLE SPENDING ACCOUNTS

Section 214 of the nearly 5,600-page bill includes additional optional flexibility for employer-sponsored Health Flexible Spending Accounts (FSAs) and Dependent Care Assistance Programs (DCAPs). These new allowed changes are in addition to the IRS guidance allowing temporary relief for FSAs and DCAPs released earlier in 2020.

Under the new law employers are permitted to allow:

- Carryover of unused funds from a Health FSA or DCAP from plan year 2020 into plan year 2021 and from plan year 2021 to plan year 2022.
- Extension of Health FSA or DCAP grace periods for 12 months following the end of the plan year.
- Employees to receive reimbursements from unused benefits or contributions through the end of the plan year after they ceased participation in a Health FSA in 2020 or 2021.
- An increase to the maximum age for reimbursable DCAP expenses from age 13 to 14 when the dependent aged out during the pandemic.
- Modifications to Health FSA and DCAP election amounts prospectively.

Employers are permitted, but not required to allow any or all of these changes. Employers wishing to make these changes must amend their cafeteria plans. The IRS will allow plan amendments to be retroactive if amendments are adopted by the end of the first calendar year beginning after the end of the plan year in which the amendment is effective, and the plan is operated within the terms of the amendment beginning on the effective date of the amendment. This means 2020 plans making amendments for the 2020 plan year must have signed amendments before December 31, 2021.

NEW HEALTH AND WELFARE DISCLOSURE REQUIREMENTS

The CAA has Sections dedicated to new disclosure and reporting requirements for group health and welfare plans (GHPs). These disclosure and reporting requirements include the: (1) removal of gag clauses on network provider pricing and quality information, (2) disclosure of broker and consultant compensation, (3) analysis of a medical plan's compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), and (4) reporting of a GHPs pharmacy benefits and prescription drug costs.

Plan Identification Card Disclosures

The CAA requires additional disclosures on plan identification cards that inform participants of their applicable health plan cost-sharing (deductibles and out-of-pocket maximums) requirements. GHPs must provide the following information, in clear writing, on any physical or electronic identification card issued to participants:

- Any deductibles and out-of-pocket maximum limits applicable to the participants' plan or coverage; and
- The telephone number and web address where plan participants can obtain plan information.

These disclosure rules apply beginning January 1, 2022.

Price Comparison Tools

Under the CAA, plans and insures – including self-insurers – must provide a price comparison tool that is available by phone and on the plan's website. The price comparison tool must permit participants to compare their portion of cost-sharing under the plan for particular services and items for the plan year, based on specific (1) geographic regions, and (2) participating providers.

These disclosure rules apply beginning January 1, 2022.

Continuity of Coverage Regarding Health Providers

The CAA addresses what happens if a health provider is removed from a plan's network following termination of the network contract between the plan and provider. When this occurs, the plan or insurer must timely notify plan participants who are receiving care from the provider that:

- The provider is no longer part of the plan's network.
- The participant has the right to continue receiving transitional care from the provider.

- The plan must cover the transitional care provided by that former plan network provider at the in-network coverage level during the transitional care period.

The CAA requires plans to give the participant the opportunity to request a transitional care period. The period must extend for the remaining time that the participant is a patient at a continuing care facility or for up to 90 days after the plan participant(s) receives notification from the plan that the provider is no longer in their network.

This provision becomes effective on January 1, 2022.

Removal of Gag Clauses on Network Provider Price and Quality Information

Section 201 of the CAA amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) to require employer-sponsored GHPs to ensure access to cost and quality of care information.

Section 201 prohibits plans from agreeing to restrictions in provider network contracts that prevent the plan from accessing price and quality information – including provider-specific cost and quality of care data. According to the amendment, GHPs must provide that information to participants.

The Section 201 amendments also require GHPs to ensure they have access to specific claims data that shows the costs related to claims. However, Section 201 permits providers and provider networks to prohibit GHPs and health insurers from publicly disclosing claims data that they receive from the providers and provider networks. Section 201 requires GHPs to certify their compliance annually.

The Section 201 amendments are effective beginning January 1, 2022.

Disclosure of Compensation to Brokers and Consultants

The CAA amends Section 408(b)(2) of ERISA – requiring compensation paid to plan service providers be "reasonable" – to apply to health plan brokers and consultants. Previously, the requirements only applied to retirement plan brokers and consultants. The CAA requires GHPs to disclose compensation paid to any broker or consultant that receives $1,000 or more for their services.

The CAA adopts the following definition of *brokerage services*. Any brokerage services provided to an ERISA-covered GHP with respect to the selection of health insurance products (including vision and dental), record keeping services, medical management vendors, benefits administration, stop-loss, pharmacy benefit management (PBM) services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs (EAPs), or third party administration (TPA) services, consulting services related to the development or implementation of plan design. for an ERISA-covered group health plan.

Additionally, the amended ERISA rules require health plan brokers or consultants to disclose certain information to the plan fiduciary, including (1) a description of the services provided and (2) a description of all covered compensation (both direct and indirect).

Failure to meet the disclosure requirements means that the contract between the broker and plan is not "reasonable" under ERISA.

These disclosure rules apply to any contract executed one year after the enactment of the CAA (contracts executed on or after December 27, 2021).

Mental Health Parity and Substance Use Disorder Benefits

The MHPAEA requires a GHP to provide the same level of benefits for mental health and substance use disorders (MH/SUD) as medical and surgical (M/S) care. Under the MPHAEA, plans must offer parity between nonquantitative treatment limitations (NQTLs) placed on MH/SUD benefits and M/S benefits. NQTLs refers to any benefit limit that a GHP imposes on items and services that is not a specific monetary or visit limitation. The DOL's NQTL Noncompliance Warning Signs gives examples of NQTLs that plans must treat as the same whether imposed on MH/SUD or M/S, these examples include (1) preauthorization requirements, (2) fail-first/step therapy protocols, (3) probability of improvement evidence, (4) requirements of written treatment plans, and (5) refusal policies that patient non-compliance, residential treatment limits, geographical limitations, and licensure requirements. The CAA amends ERISA, the PHSA, and the IRC to require GHPs to formally analyze their compliance with the MHPAEA requirements related to nonquantitative treatment limitations.

The Department of Labor (DOL), Health and Human Services (HHS), and the IRS (collectively the Departments or Agencies) have enforcement authorities pertaining to the MHPAEA. Under the new MHPAEA rules created by the CAA, GHPs must document and make available, upon request, to the secretaries of the Departments an analysis of the plan's compliance with the MHPAEA NQTL requirements. The law charges the Departments to request a copy of at least 20 GHPs mental health parity analysis per year.

The new rules require the Department secretaries to issue guidance with respect to the required analysis within 18 months of the enactment of the CAA. If a participant files a complaint with one of the Departments, or the Agency secretaries suspect a violation, they can request a copy of the plan's analysis. The Departments may request a plan's analysis report as soon as 45 days after the CAA's enactment. The DOL has recently released a Self-Compliance Tool that a plan administrator can use to evaluate whether their plan complies with the MHPAEA's parity requirements.

Reporting on Pharmacy Benefits and Drug Costs

The CAA updates ERISA, the Public Health Service Act (PHSA), and the tax code to require each GHP to report certain information related to plan spending and prescription drugs to the Agency secretaries, including:

- The plan year, number of enrollees, and each state in which the plan is offered;

- Categorical data about the top 50 prescription drugs paid for by the plan, the required data disclosure includes:
- The top 50 brand prescription drugs paid for by the plan, and the total number of paid claims for each of those drugs,
- The top 50 most expensive prescription drugs paid for by the plan, and both the total annual spending, and the annual amount spent by the plan for each drug,
- The 50 prescription drugs with the greatest increase in plan expenditures since the prior plan year, and the change in amounts spent for each of those drugs,
- The total spending on health care services by plan, broken down into specific categories, including (1) hospital costs, (2) primary care costs, (3) specialty care costs, and (4) prescription drug costs;
- Reporting of the average monthly premiums paid by the employer and by the plan participants; and
- The impact on premiums by rebates and fees paid by the plan's drug manufacturers, administrators, or service providers, including reductions in premiums and out-of-pocket costs associated with the rebates and fees.

The first report is due one year after enactment of the CAA (December 27, 2021) and each subsequent report is due annually by June 1.

NO SURPRISES ACT

The No Surprises Act contains the balance billing relief portion of the CAA. When the law becomes effective on January 1, 2022, plan participants will not get balance bills when they:

- Seek emergency care at an out-of-network facility
- Are transported by an out-of-network air ambulance,
- Receive non-emergency care at an in-network hospital but are unknowingly treated by an out-of-network physician or laboratory.

In these circumstances, covered individuals will only be responsible for the cost-sharing – deductibles, coinsurance, and copayment – that they pay according to their plan's in-network terms.

All of the No Surprises Act portions of the CAA's balanced billing provisions take effect on January 1, 2022. There will be extensive rulemaking proceedings during the first half of 2021. Some of the Acts details can be found below.

Cost-Sharing Protections and Billing Transparency

Under the No Surprises Act, the only cost-sharing that the person will be responsible for is the same amount that they would have paid for that service from an in-network provider. The No Surprises Act bars providers from holding patients liable for higher amounts. It also establishes new standards for billing practices – including timelines for coordination between providers and insurers – to ensure that a patient only receives a bill that accurately reflects the in-network cost-sharing they should pay.

The Act also attempts to increase transparency for all patients and help them understand their cost-sharing liability ahead of time. Patients can receive an Advanced Explanation of Benefits (AEB) before going to a healthcare provider. The AEB provides a prospective patient with a good-faith estimate of their costs and cost-sharing responsibilities and identifies whether the provider(s) furnishing the items or services is/are in-network and, if not, how to find in-network providers. It also requires insurers to:

- Offer price comparison information by phone;
- Develop a web price comparison tool; and
- Maintain up-to-date provider directories.

Patient Protections for Emergency and Air Ambulances Services

In cases of same-day emergency services, out-of-network providers must charge patients the amount that patients would have been required to pay in cost-sharing if an in-network provider delivered the services. Patients would be protected from surprise medical bills for emergency services for evaluation and treatment until the provider stabilizes them and can receive consent to transfer the patient to an in-network facility. The protections apply when a patient receives treatment from an in-network or out-of-network provider and covers out-of-network air-ambulance services.

Patient Protections for Non-Emergency Services

The No Surprises Act protects patients from surprise medical bills for non-emergency services provided at an in-network facility by an out-of-network provider. It allows for some voluntary exceptions to surprise medical bill protections, but only if a patient knowingly and voluntarily agrees to use an out-of-network provider. Providers can also charge a patient the out-of-network fee if they have the patient complete a consent waiver before charging them. The goal is to ensure that the bill is no longer a surprise but an agreed to and understood healthcare service fee.

Providers cannot request a consent waiver in the following three circumstances:

1. When an in-network provide is available at a facility but not offered provider does not offer patients an in-network provider available in the facility;
2. When a patient receives care for unforeseen or urgent services; or
3. When a provider is an ancillary provider that a patient typically does not select (e.g., a radiologist, anesthesiologist, pathologist, neonatologist, etc.).

The Act lists those classified as ancillary service providers that cannot request that patients sign a consent waiver. The list includes:

- Emergency medicine, anesthesiologists, pathologists, radiologists, and neonatologists;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services unless they are exempted by rule; and

- Non-participating providers (if there are no participating providers at the same facility who can furnish the items or services).

It also allows federal agency officials to identify additional providers and services that cannot be excepted in future rulemaking.

Settling Payment Disputes

The most contentiously debated portion of the No Surprises Act is the payment resolution provisions. Providers favored a strict arbitration process while payors favored a price benchmarking approach. Congress arrived at a compromise; it gives insurers and providers 30 days to negotiate payment of out-of-network bills. If that fails, the claims will go through an independent dispute resolution process with an arbitrator that would set the bill's final cost.

Even though the Act does not set a benchmark price, it bars providers from using their "billed charges" during arbitration because billed charges are typically more than the negotiated rates and the actual cost of providing the care. The Act also states that arbiters cannot consider Medicare and Medicaid rates because they are much lower than what an insurer usually pays.

Instead, the No Surprise Act instructs negotiators to consider the median in-network prices paid by each insurer for the services and items in dispute. It also allows insurers to consider other factors, including whether the medical provider tried to join the insurers' network and how sick the plan participant was compared with others. It also allows consideration of network rates a provider may have agreed to during the previous four years. The rate determined by the arbitrator is binding on both the payor and provider.

No Surprises Act and State Balanced Billing Laws

If state insurance law applies to an insurance plan, that plan must follow a state's balance billing rules when a state law's provisions differ from the federal law, such as determining a payment. In such cases, the federal law defers to states.

IMPLEMENTING REGULATIONS OF THE AFFORDABLE CARE ACT NONDISCRIMINATION IN HEALTH CARE PROVIDER PROVISIONS

In 2010, the Affordable Care Act (ACA) included a provision prohibiting GHPs from discriminating, with regard to participation under a plan or coverage, against any health provider that acts within the scope of its license or certification under applicable state law. Although the Departments issued FAQ guidance in 2013 and 2015 addressing this provision, they have declined to issue any implementing regulations. Based on the ACA and Department FAQs, the nondiscrimination provision does not require GHPs or insurers to contract with any health care service provider willing to abide by the terms and conditions for participation established by the plan or insurer. In addition, this provision does not prevent GHPs or insurers from establishing varying rates of reimbursement – provider tiers – based on quality or performance measures. The provision became effective for plan years beginning on or after January 1, 2014.

The CAA requires the Departments to issue proposed regulations under PHSA Section 2706 regulating the ACA's nondiscrimination of healthcare providers provisions on or before January 1, 2022. The CAA states that following a 60-day comment period of the proposed regulations, the Departments must release their final regulations within six months of that comment period's closing.

EPIC Employee Benefits Compliance Services

For further information on this or any other topics, please contact your EPIC benefits consulting team.