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Stimulus Package Makes Major Changes with Respect to Employer Sponsored Benefit Plans

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In a year-end piece of legislation intended to fund the federal government, especially one that is 5,593 pages in length, there is always the possibility that some benefits-related items will be included, even though not as featured items. The Coronavirus Appropriations Act, 2021 (the "Act") did not include potential provisions, such as "SECURE Act 2.0," that appeared to have widespread bipartisan support. Similarly, it did not address the more contentious issue of multiemployer plan reform or contain a continuing waiver of required minimum distributions for 2021. It does include various health and welfare and retirement plan items that may require plan sponsor action in the future, as explained below.

Health and Welfare Plans

While referring to the No Surprise Billing Act Division of the Act as a mini-Affordable Care Act would not have been politically astute, it would be an accurate way to characterize the vast and complicated changes that it introduces to health plans. Generally effective for plan years beginning after 2021, the entirety of the changes is too voluminous to discuss in detail in this format. Among the many changes made by the No Surprise Billing Act Division of the Act are several related to disclosure of provider information and transparency for group health plans. In each instance, these new provisions apply to ERISA and the Internal Revenue Code (the "Code"), as well as to the Public Health Services Act.

The explanation that follows is intended as a brief summary of the Act's provisions and their effective dates so that plan sponsors can be aware of the need to plan and implement significant changes to their health and welfare plans in the future.

Patient Protection from Surprise Medical Billing

There has been widespread bipartisan support for some time with respect to the patient protection aspects of surprise billing, although there has been disagreement on certain implementation issues, such as: whether there should be an initial payment prior to dispute resolution; whether there should be a threshold amount for dispute resolution; and the factors to be taken into account by an arbiter in resolving any dispute. Under the Act, patients will be protected from surprise medical bills that could arise from out-of-network emergency care; from certain ancillary services provided by out-of-network providers at in-network facilities; and for out-of-network care provided at in-network facilities without the patient's informed consent. Plan participants will be required to pay only the in-network cost-sharing amount, which will be considered in determining the employee's deductible and out of pocket cost-sharing limitations. Both providers and health plans will be required to inform participants of these limitations, violations of which could result in state enforcement actions or a federal civil monetary penalty of up to $10,000. In order for an out-of-network provider to continue to be able to balance bill, the provider would need to inform the participant of the provider's network status, provide an estimate of charges, and obtain the participant's written consent, before performing services.

Health plans will be required to reimburse or deny claims of out-of-network providers that are subject to these surprise billing provisions within 30 days, and plan participants will not be involved in the process. If the provider is dissatisfied with the result, there is a process for review, beginning with a 30-day period within which the plan and provider will attempt to resolve the matter through negotiation. If negotiations do not lead to a settlement, the next step is independent dispute resolution by an arbiter. Unlike most arbitrations, under the Act each party will submit a final order for consideration by the arbiter. The Act lists a wide variety of factors that the arbiter might consider, although one factor an arbiter cannot consider is the rates paid by Medicare or Medicaid. The arbitration process will need to be concluded within 30 days. Following the determination by the arbiter, the parties involved cannot initiate another IDR process for the same item or service for a 90-day period.

With respect to reimbursement and dispute resolution, insured plans may be subject to state laws or policies that regulate the way certain out-of-network claims or surprise billing matters are treated. However, those state laws will not apply to self-insured medical plans. Self-insured plans will be subject to the reimbursement and dispute resolution provisions of the Act.

Plan participants using air ambulance services, but not ground ambulance services, will be accorded similar protections against surprise medical billing, and providers of these services and health plans will be afforded a similar process for resolving disputes.

Health Plan Price Transparency

Health plans will be required to send patients an advance explanation of benefits ("Advance EOB") before scheduled care or at the request of patients looking for more information. The Advance EOB will include: (1) whether the provider and facility are in-network, and either the contracted rate for the item (if in-network) or information on finding in-network providers for the item or service (if out-of-network); (2) the good faith estimate provided by the provider with a delineation by the health plan of the portion that the patient should expect to pay and the portion the health plan is expected to pay; (3) an estimate of the amount the patient has incurred toward the deductible and the cost-sharing limits; (4) information on any medical management required for the item or service; and (5) a disclaimer that all information provided in the notice is an estimate and subject to change

Maintenance of Price Comparator Tool

Each plan or issuer of group coverage must offer price comparison guidance either by phone or by making a price comparison tool for the plan available on an internet website. The price comparison tool, to the extent practicable, must allow an individual enrolled in the plan to determine the amount of cost sharing for which the individual will be responsible.

Increasing Transparency by Removing Gag Clauses

Group health plans and issuers of group health insurance coverage are precluded from entering into any agreement with a health care provider, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would, directly or indirectly, preclude the plan or issuer from doing any of the following: (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, enrollees in the plan or individuals eligible to become participants in the plan; (2) electronically accessing de-identified claims and encounter information for each enrollee in the plan including, on a per claim basis, (i) financial information, such as the allowed amount in the provider contract, provider information, including name and clinical designation; (ii) service codes, or any other data element included in claim or encounter transactions; and (iii) to the extent applicable and consistent with HIPAA and other applicable law, sharing such information with a business associate.

Extension of ERISA Section 408(b)(2) Disclosure to Health and Welfare Plans

In 2010, the DOL adopted disclosure requirements for retirement plan service providers to the relevant plan fiduciaries but, at that time, reserved the treatment of welfare plans. That reservation will be removed from the Federal Register in 2021, when the DOL implements an addition to ERISA Section 408(b)(2) providing for the disclosure of direct and indirect compensation of brokers and consultants to welfare plans.

Reporting on Pharmacy Benefits and Drug Costs

Not later than December 22, 2021, and not later than June 1 of each year thereafter, group health plans or health insurance issuers must provide to the Secretaries of Labor, Treasury, and HHS, the following information with respect to the health plan: (1) the beginning and end dates of the plan year, the number of enrollees, and each State in which the plan or coverage is offered, (2) the fifty brand prescription drugs most frequently dispensed, and the total number of paid claims for each such drug, (3) the 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent for each such drug, (4) the 50 prescription drugs with the greatest increase in plan expenditures over the plan year, and the change in the amounts expended, (5) total spending on health care services, broken down into various categories, including costs for prescription drugs, and spending on prescription drugs by the health plan or coverage and by enrollees in the plan, (6) the average monthly premium paid by employers and employees, and (7) any impact on premiums of rebates, fees, coupons, other remuneration paid by drug manufacturers to the plan, and any reduction in premiumsor out-of-pocket costs associated with these rebates, fees, coupons or other remuneration.

Not later than 18 months after the date on which the first report is required, and biannually thereafter, HHS is required to make available on its website a report on prescription drug reimbursements under group health plans, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage.

Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations

Group health plans or group health plan issuers are required to include, in clear writing, on any physical or electronic plan or insurance information card given to participants, beneficiaries and enrollees, the following information: (1) any deductible applicable to the plan or coverage; (2) any out-of-pocket maximum limitation applicable to the plan or coverage; and (3) a telephone number and internet website address through which an individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have a contractual relation with the plan or coverage for furnishing items and services under the plan or coverage.

Mental Health Parity and Addiction Equity Act ("MHPAEA") Transparency

One of the more complex aspects of the MHPAEA is its application to nonquantitative treatment limitations (NQTLs). Under the Act, beginning 45 days after the Act was enacted, medical plans that provide mental health or substance abuse disorder benefits that impose NQTLs must make available to state and federal agencies, the following information: (1) the specific plan or coverage terms regarding the NQTLs and the medical/surgical and mental health/substance abuse disorder benefits to which the NQTLs apply; (2) the factors used to determine that the NQTLs apply to medical/surgical benefits or to mental health/substance abuse disorder benefits; (3) the evidentiary standards used to evaluate the factors and any other source or evidence relied upon to design and apply the NQTLs to medical/surgical or mental health/substance abuse benefits; (4) the comparative analysis used to determine that the standards and factors used to apply the NQTLs to mental health/substance abuse disorder benefits are comparable to and no more stringent than those used to apply it to medical and surgical benefits; and (5) the specific findings and conclusions by the plan or health insurance issuer as to whether or not it was in compliance.

Provider Directory and Discrimination

Health plans will be required to maintain and keep current online directories of their in-network providers. If a patient documents that the patient has received incorrect information from a plan about a provider's in-network status prior to a visit, the patient will only be responsible for the in-network amount.

One of the provisions of the Affordable Care Act prohibited discrimination against any willing provider. The IRS, DOL and HHS concluded that the statutory language was sufficiently clear that the provision was self-implementing, and thus did not issue implementing regulations. The Act indicates Congress's disagreement with that view. It requires the agencies to propose regulations no later than January 1, 2022, and to issue final regulations no later than six months after comments are received that prohibit discrimination against any willing provider.

Flexible Spending Account (FSA) Relief

The Act provides several forms of relief for health and dependent care FSAs:

- An FSA, for its plan year ending in 2021, may allow employees to make elections without a qualifying change event as is required under existing regulations.
- A health or dependent care FSA, for its plan year ending either in 2020 or 2021, may extend the current 2½-month permitted grace period to 12 months.
- Unused funds in either type of FSA in 2020 can be carried over to 2021, and unused funds in either type of FSA can be carried over from 2021 to 2022.
- Terminated participants in a health FSA during 2020 and 2021 can continue to receive reimbursements from their unused funds through the end of the plan year (including a grace period, if applicable) during which the termination of employment occurred.
- In most instances, eligibility for dependent care assistance ends when a dependent attains age 13. Under the Act, if prior to January 31, 2020, an employee enrolled a child who either will soon turn 13 or has turned 13, there is a choice of two options: (i) reimbursement for dependent care expenses incurred for the remainder of the plan year after the child attains age 13, or (ii) if there are unused funds at the end of a plan year, those specific leftover funds could be used in the following year on a child who will attain or has attained age 13, but not after the child's fourteenth birthday.

As a general rule, amendments to a FSA must be done on a prospective basis, but the Act permits a plan to be amended retroactively so long as the plan is amended by the last day of the first plan year beginning after the end of the plan year in which the amendment is effective. An issue for administrators of FSAs to consider is the way these permissible modifications will affect nondiscrimination testing for both health plan FSAs and dependent care FSAs between 2020 and 2022.

Employer Repayment of Student Loans

The Cares Act permitted an employer to provide coverage during 2020 for student loan repayment in an amount not to exceed $5,250, accounting for other permissible reimbursements under a Code Section 127 educational assistance plan. The Act extends this provision through 2025. Considering other pandemic-related concerns in 2020, this provision likely was not utilized extensively, but with the extended period to provide the relief, there may be increased employer interest.

Retirement Plan Provisions

Temporary Rule Addressing Partial Plan Terminations

The IRS was aware of the potential for partial plan terminations due to the pandemic and provided some relief earlier this year, but Congress's action is more expansive. The Act provides that a tax-qualified plan will not incur a partial plan termination, which would require the full vesting of all affected employees, if during any plan year that includes the period beginning on March 13, 2020, (the date the national emergency was declared) and ending on March 31, 2021, the number of active participants covered by the plan is at least 80% of the number of participants covered by the plan on March 13, 2020. While this rule applies to both defined contribution plans and defined benefit pension plans, because many defined benefit plans are not fully funded, sponsors of defined contribution plans will be the primary beneficiary of this temporary rule. Further, the Act is an explicit Congressional recognition of the IRS's more objective (but hitherto nonstatutory) standard providing that a 20% reduction in active participants may constitute a partial plan termination.

Money Purchase Pension Plan Relief

Under the CARES Act, if certain conditions were satisfied, affected participants could receive a coronavirus-related distribution from their retirement plan accounts. Technically, the CARES Act provisions were applicable to money purchase pension plans but did not permit in-service distributions from money purchase pension plans if such distributions were not otherwise available, i.e., not before age 59½ at the earliest. The Act, on a retroactive basis, permits in-service coronavirus-related distributions. The practical difficulty is that the Act does not appear to extend the period for obtaining coronavirus-related distributions beyond December 31, 2020, and the IRS previously announced that in-service distributions from money purchase plans would not qualify for coronavirus-related distribution treatment. Further IRS guidance will be needed on this issue, but it seems that Congress is, in effect, bailing out participants in money purchase pension plans who received distributions contrary to IRS guidance.

Election to Terminate Transfer Period for Qualified Transfers Covering Future Retiree Costs

Code Section 420 permits qualified future transfers under which up to10 years of retiree health and life costs may be transferred from a company's pension plan to a retiree health benefits account and/ or a retiree life insurance account within the pension plan. Such transfers must satisfy funding and reversion conditions, including: (1) the plan must be 120% funded at the outset; (2) the plan must be 120% funded throughout the transfer period; and (3) at the end of the transfer period, all unused amounts must be returned to the pension plan. According to the legislative history, applying the current law requirements during the market volatility related to the coronavirus pandemic has caused plans that have historically been far over 120% funded to fall below 120% as of a specific date, and face a requirement to immediately restore the market losses to again become 120% funded even if the funding level had been restored to 120% or more by a later date. The Act allows employers to make a one-time election during 2020 or and 2021 to end any existing transfer period for a taxable year beginning after the date the election is made, provided that, among other things: (1) the employer ensures that the plan stays at least 100% funded during the original transfer period; (2) the plan has met funding targets for the first five years after the original transfer period; and (3) all amounts left in the retiree benefits account at the end of the shortened transfer period are returned to the pension plan (without application of the excise tax to such amounts).

Disaster-Related Distributions and Loan Relief

Disaster relief options for retirement plans that have been available historically to plan sponsors have been extended to disasters occurring from December 28, 2019, through December 27, 2020, that are declared disasters by the President during the period beginning January 1, 2020, and ending 60 days after December 27, 2020. These disaster areas, however, specifically exclude disaster areas that are disaster areas solely due to the pandemic, because those disasters were addressed under the CARES Act. The relief appears to be optional,

but plan sponsors implementing these provisions will have until the last day of the 2022 plan year to adopt the necessary plan amendment. Relief includes qualified disaster distributions and disaster-related plan loans, like the relief provided under the CARES Act, as well as the ability, for a limited time period, to recontribute amounts received as a hardship withdrawal to purchase a principal residence.

Phased Retirement for Certain Multiemployer Pension Plan Participants

In-service distributions are allowable at age 55 only to certain participants in multiemployer pension plans. Nevertheless, the earliest age for in-service distributions from a tax-qualified money purchase pension plan or defined benefit pension plan remains age 59½.

Employers sponsoring retirement, health and welfare plans should begin educating themselves on the extensive regulatory provisions of the Act affecting employee benefit arrangements. Significant time will need to be spent on planning as to benefit design in order to remain in compliance with the new plan requirements. This is intended as a brief summary to alert employer plan sponsors to the many benefit plan changes in the Act so that sponsors will be aware of the need to plan and implement design changes to keep their benefit plan programs in compliance. Please reach out to one of the article authors if you have questions or would like additional information.

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