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Consolidated Appropriations Act, 2021 — Understanding the Health and Welfare and Retirement Provisions

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Consolidated Appropriations Act, 2021

- The Consolidated Appropriations Act, 2021 (CAA) was signed by the President on December 27, 2020
- It is 5,593 pages in length
- We will be proving a high-level overview of certain employee benefit plan provisions
  - We cannot discuss them all in detail
- Some of the provisions are currently in effect, with other provisions becoming effective in later years

CAA — Important Contract and Budget Issues

- For many health and welfare plan provisions, an employer will be required to amend vendor contracts and obtain budgets to handle these new requirements
  - We believe that for self-funded health plans, employers should understand the impact of these rules now, as in most cases the plan sponsor is the entity responsible for compliance
- For certain retirement plan provisions, an employer will need to provide direction to the plan's third-party administrator and amend its plan documents

Agenda: Health and Welfare Plan Topics

- We will focus on two main aspects of the CAA
- #1 — Permitted changes to health FSAs and dependent care FSAs
- #2 — Certain provisions in Title I and Title II of Division BB — Private Health Insurance and Public Health Provisions
  - Title I and Title II are pages 1628-2086 in the CAA (over 450 pages)
  - We will not discuss all Health and Welfare provisions – rather, we will focus on most of the provisions for which plan sponsor action is needed now (or very soon!)

Agenda: Health and Welfare Plan Topics

Title I -- No Surprises Act

- Sections 102 and 103 -- Health insurance requirements regarding surprise medical billing and the determination of out-of-network rates to be paid by health plans; Independent dispute resolution process
- Sections 105 and 106 -- Ending surprise air ambulance bills and the reporting requirements regarding air ambulance services
- Section 107 -- Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations
- Section 111 -- Consumer protections through health plan requirement for fair and honest advance cost estimate (Advanced EOBs)
- Section 113 -- Ensuring continuity of care
- Section 114 -- Maintenance of price comparison tool
- Section 116 -- Protecting patients and improving the accuracy of provider directory information

Agenda: Health and Welfare Plan Topics

Title II -- Transparency

- Section 201 -- Increasing transparency by removing gag clauses on price quality and information
- Section 202 -- Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans
- Section 203 -- Strengthening parity in mental health and substance use disorder benefits
- Section 204 -- Reporting on pharmacy benefits and drug costs

Agenda: Retirement Plan Topics

- Qualified Disaster-related Relief Provisions
  - Qualified Disaster Distributions
  - Disaster-related Plan Loans
  - Return of Withdrawals for Home Purchase/Construction
- New COVID-19 Pandemic Related Relief Provisions
  - Partial Plan Termination Temporary Relief
  - In-Service Distributions During Working Retirement
  - Expansion of CRDs to Money Purchase Pension Plans
  - Relief for Qualified Future Transfers

CAA — Health and Welfare Provisions

- There are 3 main ideas in these provisions:
  - Access — Allow employees additional time to access amounts in the Dependent Care Flexible Spending Account Plans (DC FSAs) and the Health Care Flexible Spending Account Plans (Health FSAs)
  - Limitations — Reign in the costs of certain out-of-network (OON) "surprise" billing and air ambulance costs
  - Transparency — Report on the costs of health plan service and prescription drug costs and require transparency for certain limitations and restrictions placed on mental health benefits under the Mental Health Parity and Addiction Equity Act (MHPAEA)

CAA — Flexible Spending Account Provisions

- These are temporary special rules for Health FSAs and DC FSAs (together referred to as "FSAs")
- Each of these FSA provisions are permissive — a company is not required to adopt any of these provisions
- If a company does decide to amend for these FSA provisions, it will first need to confirm with its FSA third-party administrator (TPA) that the TPA can administer these new FSA provisions before communicating these provisions to its employees
- For any FSA changes, notification must be provided to eligible employees, however, the CAA allows additional time for companies to adopt formal plan amendments

FSAs — Carryover Provision

- The CAA has expanded the carryover provision
- A company can amend its limited purpose Health FSA, general purpose Health FSA and/or DC FSA to allow participants to carry over ALL unused amounts from the 2020 plan year to the 2021 plan year
- A company also can amend its FSAs to allow participants to carryover ALL unused amounts from the 2021 plan year into the 2022 plan year

FSAs — Carryover Provision

- The current Internal Revenue Code ("Code") Section 125 rules provide that a Health FSA may allow carryover of unused balances of up to $550 (indexed) remaining at the end of a plan year, to be used for qualified medical expenses incurred in a subsequent plan year
- The CAA FSA provisions temporarily remove this cap
- Example: Assume that a participant in a calendar year Health FSA had $900 left in his Health FSA as of December 31, 2020. That $900 can be carried over into 2021 plan year. The carryover amount will not decrease the maximum salary contribution amount that the participant can make for the 2021 plan year (i.e., the participant can still elect to contribute the maximum amount of $2,750)

FSAs — Carryover Provision

- For a company that offers a high deductible health plan ("HDHP") and wishes to adopt the carryover provision, the company will need to decide how it will design this carryover feature so that it does not impact an employee's eligibility to contribute to a Health Savings Account ("HSA")
- A carryover to a general purpose Health FSA will make the participant ineligible to contribute to their HSA for the entire subsequent plan year
- A reasonable Health FSA design could include the carryover being automatically converted to a limited purpose Health FSA if the participant enrolls in an HDHP or allowing participants to irrevocably decline the carryover
  - These types of carryover designs will allow a participant to maintain HSA eligibility

FSA — Carryover Provision

- The carryover provision must be offered to all eligible employees in the FSA and not just select groups of participants covered under the plan
- Current guidance provides that Health FSA carryovers can be limited to individuals who have elected to participate in the employer's Health FSA in the next plan year
  - This plan design is permitted even if a minimum salary reduction is required for participation

FSA — Carryover Provision

- Prior to the CAA, carryovers were not permitted for DC FSAs
- Under the CAA, a DC FSA may be amended to temporarily include a carryover
- We do not believe that the carryover will count towards the annual maximum contribution limit for a DC FSA
  - We expect that the IRS will provide guidance on this issue soon

FSA — Grace Period

- Instead of having an FSA carryover, a company may provide a 12-month grace period at the end of the 2020 plan year during which all unused 2020 plan year FSA amounts will be available for incurring claims during the subsequent 12 months
  - An FSA cannot have both the carryover provision and the grace period — It can have one or the other
- This extended 12-month grace period is also available for unused FSA amounts at the end of the 2021 plan year
- Under the current Code Section 125 rules, a cafeteria plan may allow participants to access unused amounts after the end of a plan year to pay or reimburse expenses for qualified benefits incurred during a "grace period" of up to two months and 15 days after the close of the plan year. The CAA extends this "two months and 15 day" grace period to 12 months

FSA — Grace Period

- Example. Assume that a participant participates in a calendar year FSA that has adopted the extended 12-month grace period. The participant has $1,000 remaining unused in their FSA at the end of the 2020 plan year. The participant can be reimbursed for eligible expenses incurred from 1/1/2021 through 12/31/2021 from their $1,000 2020 plan year FSA balance.

FSA — Grace Period

- The grace period provision does not work well in a general purpose Health FSA if a company wishes to facilitate employees' eligibility to contribute to an HSA
- An employee who is covered by a general purpose Health FSA and is entitled to a grace period will be ineligible to make or receive HSA contributions for the duration of the grace period. Further, under current guidance, participants cannot waive the grace period and the grace period must apply uniformly to all participants
- However, we believe that a general purpose Health FSA can have a plan design in which the grace period automatically converts to an HSA-compatible FSA during the grace period, but that such a design must be applicable to all employees in the Health FSA (even those not enrolled in an HDHP)

Carryover vs Grace Period

- As an example for 2020 money, for the grace period rule, the claim can be incurred during that grace period. The grace period money can be used for 2020 and for 2021—but the 2020 grace period money ends at 2021
- The carryover amounts are amounts not used in 2020. They can carryover to 2021—and if not used in 2021, can carryover to 2022
- The distinctions between the grace period and the carryover were more clear when the grace period was a 2 ½ month period and there was a cap on the carryover amount
- Before CAA, one could think about the distinctions in terms of risk. A carryover provision allowed unused funds to remain available for a longer duration than the grace period—perhaps even indefinitely vs. for up to two months and 15 days under the grace period. On the other hand, the grace period applies to all unused funds, while carryovers were subject to a $550 (indexed) limit

FSA — Spend Down

- A Health FSA can permit participants who terminate employment mid-year to continue to incur claims for the remainder of the year (including any grace period). This would be permitted for 2020 and 2021
- A spend down provision for a general use Health FSA would make an individual ineligible to make or receive HSA contributions
- Existing IRS rules already permit a spend down feature for DC FSAs. Accordingly, DC FSA spend downs were not addressed in the CAA

FSA — Spend Down

- There are some questions about how this would work for a Health FSA
  - While not clear, it appears that an individual could decline this spend down coverage. This may be important for a former employee who wants to opt-out of a general use Health FSA from his/her former employer so that he/she can be eligible for an HSA with a new employer
  - What amount is available for the spend down? The elected amount or the contributed amount?
    - We believe it is the contributed amount
  - How will this work with COBRA?
- Guidance from the IRS is needed

Additional FSA Election Changes Permitted

- For plan years ending in 2021, a company can amend its FSAs to allow participants in the FSAs to make election changes mid-year—without having a qualified change in status event. It appears that FSAs can be amended to permit employees who have not elected to make FSA contributions for 2021 to make new elections to contribute mid-year
  - Elections can only be made on a prospective basis
  - This election change opportunity only applies to FSAs. Unlike prior IRS relief, this mid-year election change opportunity does not apply to medical, dental, and/or vision elections
  - Prior to allowing such mid-year elections, a company will need to understand if its FSA TPA can support these changes and the associated cost

Additional FSA Election Changes Permitted

- The language in CAA does not provide any detail on the permitted elections
- For example, can an employer limit the amount of a decreased Health FSA election to NOT be less than the amount that has already been reimbursed to an employee?
- Some employers are considering offering two election change periods in 2021 for DC FSAs—one now and one later in the year (such as July), when employees have a better idea if children can attend summer camps, after school programs in the fall, etc….
  - Offering two election change periods for a Health FSA is less attractive due to the uniform coverage rules

Dependent Care FSA — Definition of Child

- The CAA increases the maximum age of a dependent child for purposes of eligible dependent care expenses to age 14, from age 13, but with some limitations
- For a qualifying child who turned age 13 during the last plan year, the Dependent FSA can be amended to allow reimbursement of expenses related to such child's dependent care for the remainder of the plan year (if the enrollment period ended on or before January 31, 2020)

Dependent Care FSA — Definition of Child

- For example, for a calendar year plan, the rule applies to a DC FSA participant who was enrolled in the plan in 2020 and who had a dependent child who turned age 13 during 2020
- In addition, if the DC FSA has adopted the carryover feature, this rule will allow for the reimbursement of expenses for dependent care provided to such child in the following plan year until the child turns age 14, but only with respect to unused amounts carried over from 2020 into 2021
- Note that the plan documents and summaries should be amended to be clear on this rule. The plan could refer to the Code section that was revised to age 14 but also include the age 13 limitation

FSAs — Plan Amendments & Additional Guidance

- If a company wants to make any of these permitted changes to its FSAs, it must amend the FSAs no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective
  - For example, no later than December 31, 2021 for an amendment that provides for a carryover of 2020 amounts from a calendar year FSA
- We believe that the IRS will issue additional guidance on these rules

FSAs — Action Items!

- A company should consider taking the following actions related to the FSA CAA provisions:
  - Discuss if the company's FSAs should be amended for any of the permissive provisions described above
  - For any plan changes being considered, the company should discuss with its FSA TPA if it is able to implement the changes — and the costs associated with those changes
  - Develop and distribute communications to employees about the FSA plan changes
  - Draft and adopt FSA plan amendments

No Surprises Act

- The No Surprises Act -- Title I of Division BB -- Private Health Insurance and Public Health Provisions
- This part of CAA contains numerous provisions, which are listed at the beginning of this webinar
- We will provide a high-level overview of many of the provisions in the No Surprises Act. However, note that these rules are complex and guidance is needed from the Departments of Labor (DOL), Treasury and Health and Human Services (HHS)
- We will review action items to be taken now by employers

No Surprises Act

- The No Surprises Act amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (Code) and the Public Health Service Act (PHSA)
- It requires both fully-insured group health plans and self-insured group health plans ("GHPs") to hold health plan participants harmless from the impact of surprise medical bills
- It does not appear to apply to excepted benefits (such as EAPs)
- Guidance is needed to confirm whether retiree-only GHPs are also exempt

No Surprise Billing (Part of the No Surprises Act)

- Applies to plan years beginning on and after January 1, 2022
- Participants are only required to pay the in-network benefit cost-sharing amount for:
  - Out-of-Network (OON) benefits for emergency care services;
  - Certain ancillary services provided by OON providers at in-network facilities (e.g., anesthesiologist); and
  - OON care provided at in-network facilities without the participant's informed consent
- For these services, participants will be required to pay only the in-network cost-sharing amount, which will be considered in determining the participant's in-network deductible and out-of-pocket maximums (OOPM)

No Surprise Billing

- For the nonemergency services provided by OON providers at in-network facilities, the CAA does allow for an exception to these rules if the patient knowingly and voluntarily agrees to use the OON provider
- The exception for a knowing and voluntary consent waiver will not apply if: (1) there is no in-network provider available in the facility; (2) the care is for unforeseen or urgent services; or (3) the provider is an ancillary provider that a patient typically does not select (e.g., a radiologist, anesthesiologist, pathologist, etc.)
- If the knowing and voluntary consent rule applies, the provider must generally notify the patient in writing 72 hours before services are scheduled to be delivered—and this notification must include a good-faith cost estimate and identify available in-network options for obtaining the service

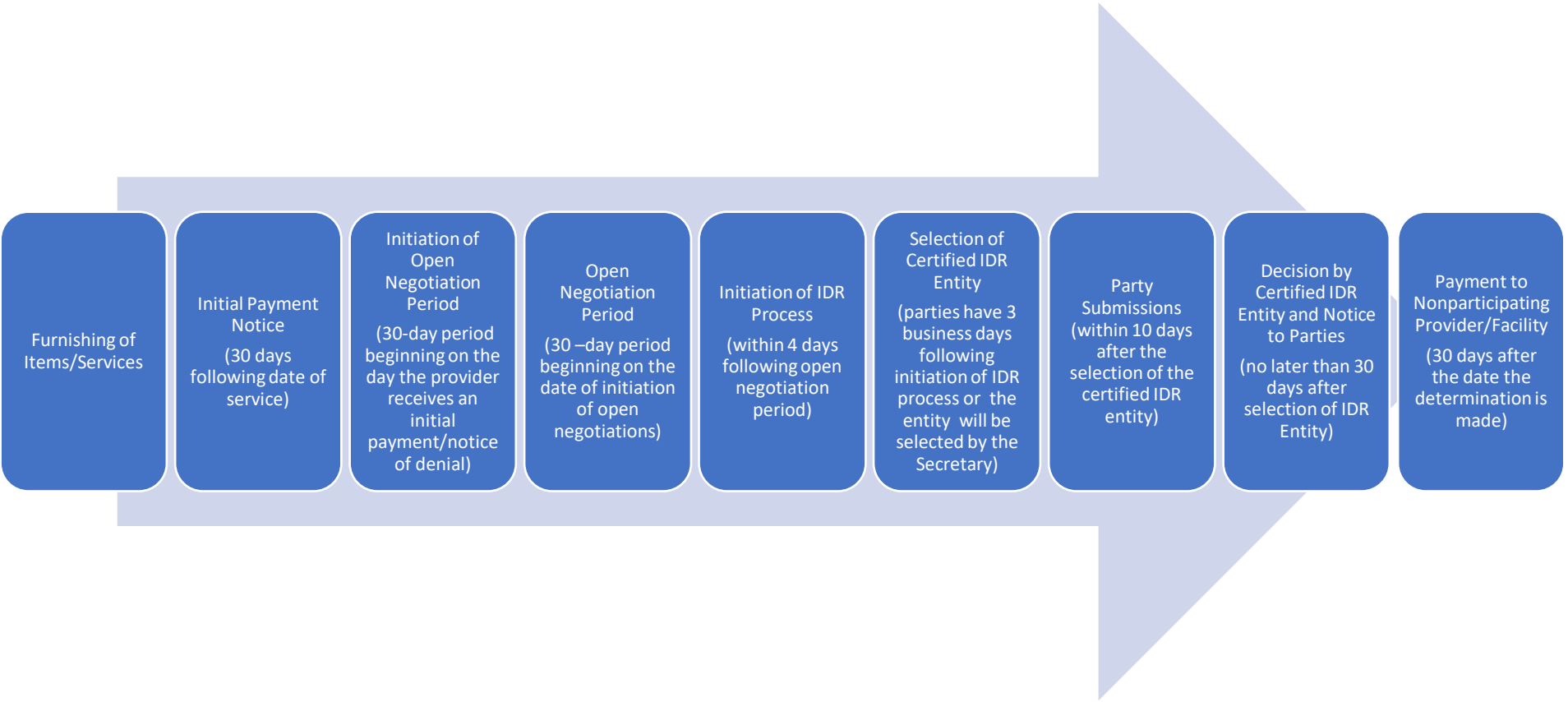
No Surprise Billing

- The plan must make initial payment or issue a denial within 30 days of receiving the provider's bill
- If the plan and provider cannot come to an agreement, claims may be submitted to arbitration initiated by the plan or the provider (known as Independent Dispute Resolution (IDR) or the "IDR process")
- Numerous factors will be reviewed by the IDR (which are set forth in the CAA), but the IDR cannot reference Medicare claims data or provider billed charges in determining the price
- The losing party must pay the cost of the entire arbitration

No Surprise Billing

- Rather than being subject to the IDR rules in the previous slide, insured GHPs may be subject to State laws that regulate the way certain OON claims are treated
  - Not all States have such laws, in which case the CAA provisions will apply
  - In addition, those State laws will not apply to self-insured GHPS
  - Self-insured GHPs will be subject to the IDR laws in the CAA

High-Level Overview of IDR Process



No Surprise Billing

- The applicable Agencies (Treasury, DOL or HHS) can audit the GHPs in response to a complaint
- The complaint process will be set forth in regulations
- The applicable agencies will also audit 25 GHPs per year

No Surprise Billing

- Plan sponsors should consider what they will need to do to prepare for the application of these provisions, including:
  - For self-funded plans, amending TPA agreements to ensure that the TPA will respond within that 30-day period and the penalty for the failure to do so
  - Understand if the plan sponsor will pay the full cost of arbitration in the event the TPA is the losing party
  - Obtain information from the insurance carrier and the TPA of the expected increased cost of compliance with these rules

Air Ambulance Claims

- This provision is effective for plan years beginning on and after January 1, 2022
- If the GHP covers in-network air ambulance services, then participants can only be required to pay the in-network cost-sharing amount for OON air ambulances
- The amounts paid by participants for such OON air ambulances must accumulate towards the participant's in-network deductible and OOPM
- Similar IDR provisions apply to these air ambulance claims
- These protections do not apply to ground ambulance

Air Ambulance Claims

- GHPs must provide reports to the applicable Agency (Treasury, DOL, HHS) on the air ambulance claims
- Air ambulance providers are required to submit cost data to the Secretaries of HHS and Transportation
- The CAA includes a long list of the information to be provided
- This is needed in order to build a reliable reference database for understanding the cost of these claims
- The plan sponsor action items for this provision are similar to those listed in the "No Surprise Billing" section of this webinar, with the addition of understanding the cost associated with this reporting

Transparency of Deductibles and OOPMs

- This provision is applicable for plan years beginning on and after January 1, 2022
- Any physical or electronic identification card must include:
  - Any deductible applicable to such GHP coverage (both in-network and OON);
  - Any OOPM limitation applicable to such GHP coverage; and
  - A telephone number and website address through which an enrollee may seek assistance, such as information related to in-network hospitals and urgent care facilities
- A plan sponsor will need to ensure that agreements with an insurance carrier and/or TPA will contain provisions requiring compliance with this new rule

Protections Against Provider Discrimination

- The Patient Protection and Affordable Care Act (ACA) contained a provision that prohibited discrimination against any willing provider
- The applicable Agencies never issued regulations but rather stated that the statutory language was sufficiently clear. The CAA shows that Congress does not agree because 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
- It is unclear what these regulations will require of GHPs

Advanced Explanation of Benefits (EOBs)

- This applies for plan years beginning on and after January 1, 2022
- Upon request, GHPs must send participants an advanced explanation of benefits (EOBs) before scheduled care
- This advanced EOB must include a list of information contained in the CAA (described in the next slide)
- In most cases, this advanced EOB is due 1 business day after the date on which the plan receives notice from the provider regarding the scheduled item or service (or, in the case of a service scheduled at least 10 business days before the service is performed, not later than 3 business days)

Advanced EOBs - Contents

- This is to be provided via mail or electronic means, as requested by the enrollee (or the enrollee's authorized representative) and must include the following information:
  - Whether or not the provider or facility is in-network
    - If in-network, the contracted rate under the GHP for such item/services (based on billing and diagnostic codes)
    - If not, a description of how that individual can obtain information on in-network providers of those services
  - A good faith estimate of the cost based on the billing and diagnostic codes identified in the notice furnished by the provider or facility based on the billing and diagnostic codes

Advanced EOBs – Contents Cont'd

- A good faith estimate of:
  - the amount the GHP is responsible for paying
  - the amount of any cost-sharing the enrollee must pay
  - the amount that the enrollee has incurred toward meeting the limit of financial responsibility under the GHP as of the date of the notice (such as the deductible and OOPM)
- In the case of a service subject to medical management techniques (such as prior authorization or step-therapy), a disclaimer that the service is subject to such medical management
- A disclaimer that the information is only an estimate and subject to change
- Any other information or disclaimer the GHP determines is appropriate

Advanced EOBs – GHP Considerations

- This is a lot of information!
- A plan sponsor should consider how it will describe the right to this advanced EOB in the summary plan description (SPD) and that it is not a guarantee of the costs associated with the service
- The plan sponsor will need to ensure that the insurance carrier and TPA will comply with these rules and who is responsible for any penalties (and costs) associated with not providing this advanced EOB (or one that has extremely wrong information)

Continuity of Care - Requirement

- This provision is effective for plan years that begin on and after January 1, 2022
- If a provider contract is terminated (so that the provider is longer an in-network provider), the plan must provide an affected "continued care patient" notice of the following:
  - The contract is terminating
  - The patient has the right to elect continued transitional care from that provider
- The plan must permit the "continuing care patient" to elect to continue to have the applicable benefits from that provider on the same terms and conditions as would have applied had the contract not terminated for a specified period

Continuity of Care – Requirement Continued

- The period of transitional continued care under this rule commences as of the notice date and ends on the earlier of 90 days following the date of the notice or the date on which the patient is no longer a "continuing care patient" with respect to the provider/facility
- This provision does not apply to for-cause terminations of a provider (e.g., provider fails to meet quality standards or commits fraud)

Continuity of Care – "Continuing Care Patient"

- A "continuing care patient" means an individual who:
  - is undergoing a course of treatment for a serious and complex condition from the provider or facility;
  - is undergoing a course of institutional or inpatient care from the provider or facility;
  - is scheduled to undergo nonelective surgery from the provider;
  - is pregnant and undergoing a course of treatment for pregnancy from the provider; or
  - is determined to be terminally ill and is receiving treatment for such illness from the provider or facility

Continuity of Care – Action Items

- Action Items:
  - Understand how the TPA or insurance carrier will determine impacted enrollees and provide the required notice to such continued care patients
  - Update the SPD to explain how this rule works
  - Understand the cost impact of this rule

Price Comparison Tool - Requirement

- This provision is effective for plan years that begin on and after January 1, 2022
- The GHP must offer price comparison guidance by phone and make available on the plan's (or issuer's) website a price comparison tool that (to the extent practicable) allows an individual enrolled under the plan to compare the amount of cost-sharing that the individual would be responsible for paying with respect to a specific item or service with respect to the following:
  - Plan year
  - Geographic region
  - Participating providers

Price Comparison Tool – Action Items

- Action Items:
  - Many TPAs and insurance carriers already have some kind of tool similar to this — plans should understand what currently exists and what needs to be updated
  - Understand the cost impact of updating this tool
  - Address in the agreements which party is responsible for major errors in the tool
  - Understand the disclaimer language that will be included with the tool

Accuracy of the Provider Directory - Overview

- This provision is effective for plan year beginning on and after January 1, 2022
- Big Picture – a GHP is required to ensure that its provider directories for in-network providers are up-to-date and that participants can access the updated directory online or call (and have a written response within 1 business day)
- Consequence of Inaccurate Information - An enrollee who relies on inaccurate provider directory information is responsible only for the in-network cost-sharing for the applicable services received from that provider (this applies too if the information was not properly provided)

Accuracy of the Provider Directory

- More information on the details of the rule!
- A plan must establish each of the following:
  - Verification process
  - Response protocol
  - Database

APD - Verification Process

- The Verification Process:
  - Not less frequently than once every 90 days, the plan must verify and update the provider and facility directory
  - Establish a procedure for the removal of a provider or facility if the plan has been unable to verify the information
  - Update the database within 2 business days of receiving updated information from the provider or facility

APD – Response Protocol

- Response Protocol:
  - For an individual enrolled in the plan who requests information by the phone or the internet on whether a provider or facility has a contractual relationship (in-network) to provide services, establish a response protocol
    - In the case of a request made by phone, the plan must respond no later than 1 business day via electronic or print communication (and maintain the communication in the individual's file for at least 2 years)
- *Note:* The take-away here is that there needs to be a process that provides the person with written documentation

APD - Database

- Database - The plan must establish a database on the public website of the plan (or issuer) that contains:
  - A list of each provider and facility that has a direct or indirect contractual relationship with the plan; and
  - Directory information (name, address, specialty, phone number and digital contact information)
- For a print directory, a notification that the information in the directory was accurate as of the date of publication and to consult with the updated database referred to above

APD – Action Items

- Action Items:
  - Ensure that the ASA contract states that the plan will meet the accuracy of provider directory information requirements and disclosure requirements
  - If there is an error, that the TPA or insurance carrier indemnifies the plan sponsor for any additional costs
  - Ensure that the TPA maintains the required documentation needed for a response to a telephone call and that such documentation will be provided to the next TPA

Title II - Transparency

- The next slides are about Title II of Division BB -- Private Health Insurance and Public Health Provisions
  - Section 201 – Increasing transparency by removing gag clauses
  - Section 202 – Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans
  - Section 203 – Strengthening parity in mental health and substance use disorder benefits
  - Section 204 – Reporting on pharmacy benefits and drug costs

Removal of Gag Clauses on Price and Quality Information

- There is no effective date specified in the CAA for this provision, so it appears to be effective now
- Big Picture – The CAA prohibits a GHP from entering into contracts with other parties that restrict (directly or indirectly) the GHP from obtaining and sharing certain information

Removal of Gag Clauses

The GHP cannot enter into contracts with health care providers, networks, association of networks, TPAs or others who offer access to a network of providers, if the contract would restrict the plan from:

- #1--Providing provider-specific cost or quality of care information or data through a consumer engagement tool or other means, to referring providers, the plan sponsor, enrollees or individuals eligible to be enrollees;

Removal of Gag Clauses Cont'd

- #2--Electronically accessing de-identified claims information for each enrollee in the plan (in accordance with HIPAA, GINA and the ADEA) including, on a per claim basis:
  - Financial information, such as the allowed amount, or any other claim-related financial obligations;
  - Provider information, including name and clinical designation;
  - Service codes; or
  - Any other data element included in a claim
- #3—Sharing information or data described in #1 and #2 above with a business associate (as defined under HIPAA)

Removal of Gag Clauses

- The agreement can allow the health care providers or networks to include reasonable restrictions on the public disclosure of the information
- The health plan must submit an annual attestation to the IRS/DOL/HHS that the plan is in compliance with this rule

Removal of Gag Clauses – Action Items

- Action Items:
  - The plan sponsor will need to review its contracts and remove these gag clauses
  - Remember that this information can be obtained and ensure that it is considered in the next RFP conducted by the plan sponsor

Disclosure Requirements for Brokers & Consultants

- ERISA contains prohibited transaction rules that limit the types of agreements and transactions that a health plan can enter into with a party-in-interest
- There is an exemption under ERISA Section 408(b)(2) that allows a plan to pay reasonable compensation to a party-in-interest
- For the last 10 years, there have been specific regulations for retirement plans, but the section in the regulations for health and welfare plans was "reserved"
- The CAA adds specific disclosure requirements for health plans so that no contract with a health plan broker or consultant is considered "reasonable" unless certain disclosures are made

Disclosure Requirements for Brokers & Consultants

- The new rules apply to any of the following covered service providers who reasonably expect $1,000 or more in compensation (as adjusted):
  - Brokerage services provided to an ERISA health plan with respect to the selection of health insurance (including vision and dental), recordkeeping services, medical management vendors, benefits administration, stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools, disease management vendors, compliance services, TPA services, etc….
  - Consulting services provided to an ERISA health plan related to the development or implementation of plan design, insurance selection, (including vision and dental), recordkeeping, medical management, benefits administration selection, stop-loss insurance, pharmacy benefit management services, wellness design, transparency tools, etc….

Disclosure Requirements for Brokers & Consultants

- The information that must be disclosed includes:
  - Description of the services
  - If the service provider will provide fiduciary services
  - A description of all direct and indirect compensation the provider (or its affiliates or subcontractors) reasonably expects to receive in connection with the services
  - If the compensation is paid among the provider, its affiliate or subcontractor on a transactional basis (like a commission or production bonus), a description of the arrangement
  - A description of amounts received in connection with the termination of the contract
  - And additional information not included on this slide

Disclosure Requirements for Brokers & Consultants

- This information must be disclosed to the responsible plan fiduciary before the contract is entered into, extended or renewed
- The plan fiduciary must be notified of any change to the required disclosures no later than 60 days from the date that the service provider is informed of the change
- There is a good faith reliance standard in the rule for the responsible plan fiduciary, but it must take reasonable steps to obtain missing information and correct any incorrect information upon discovery
  - If that fails, the plan fiduciary must provide notice to the DOL (containing specific information) and consider terminating the contract

Disclosure Requirements for Brokers & Consultants

- The rule becomes effective as of December 27, 2021
- Notably it is limited to brokers and consultants. It does not apply to an insurance carrier or pharmacy benefit manager (PBM)
- It appears that the rules apply only if ERISA plan assets are used
  - If the plan is funded by a trust, then in most cases ERISA plan assets will be used
- What if there is no trust?

Disclosure Requirements for Brokers & Consultants

- Participant contributions are plan assets. Generally, plan assets must be held in trust. However, if the *sole* reason that a plan would be considered funded (and need a trust) is the presence of participant contributions under a cafeteria plan, the plan will be deemed to be unfunded for trust purposes (DOL Technical Release 92-01)
- This does not mean that there are no plan assets. Rather, the DOL Technical Release says that the DOL will not enforce the trust requirement solely because there are participant contributions

Disclosure Requirements for Brokers & Consultants

- Example: Assume that there is no trust, the health plan is fully-insured and part of the premiums are paid by participants. Also assume that the broker is paid commissions from the insurance carrier for the placement of that plan.
  - Are plan assets involved because the commission is likely paid based on the insurance premium payments—which are in part paid by participant contributions (plan assets)? We believe the answer is yes
- For a self-funded plan that does not have a trust, what if certain administrative costs are used in determining the premium?
- The DOL will need to issue guidance on how these rules apply to health plans that do not pay broker or consultant fees from a trust
  - This will be important because brokers and consultants may claim that all costs are paid by the employer and no plan assets are involved

Disclosure Requirements for Brokers & Consultants

- Action Items:
  - Understand which plans are funded by a trust
  - Locate and review all broker and consultant agreements with the GHPs and know the terms of the agreement (and when it renews)
  - Understand if the broker or consultant for the GHP is paid any amounts from an insurance carrier
  - Understand how the premiums for a self-funded GHP is determined and what "reasonable costs" are included in those rates
- Again, we hope that guidance will be issued by the DOL about the scope of this rule for health plans not funded by a trust
- Remember that similar rules for the retirement plans created many class action lawsuits, so understand the amount of indirect compensation paid to these providers

Mental Health Parity Transparency

- The earliest these rules could apply is February 10, 2021 (which is explained later in this webinar)
- The CAA also provides that guidance must be issued within 18 months after the CAA was passed to address how these new requirements are to be implemented

Mental Health Parity Transparency

- If a GHP provides both medical & surgical benefits ("medical/surgical") and mental health or substance abuse use disorder benefits ("mental health") and the GHP imposes nonquantitative treatment limitations (NQTLs) on mental health benefits, the plan must perform and document comparative analysis of the design and application of NQTLs
- This analysis must be made available to a state authority, DOL or HHS beginning 45 days after the enactment of the CAA (February 10, 2021), but only upon request from one of those agencies
- We think a request will come from those agencies if they receive a complaint from a participant about the plan's NQTLs

Mental Health Parity Transparency

- The analysis must include a list of data that included in the CAA, such as:
  - The specific plan terms and other relevant terms regarding the NQTLs and a description of all medical/surgical & mental health benefits to which each term applies in each respective benefits classification
  - The factors used to determine that the NQTLs will apply to medical/surgical & mental health benefits
  - The evidentiary standards used for the factors described above when applicable (provided that every factor shall be defined) and any other source or evidence relied upon to design and apply the NQTLs

Mental Health Parity Transparency

- The comparative analysis demonstrating that the process, strategies, evidentiary standards, and other factors used to apply these NQTLs to mental health benefits, as written and in operation, are comparable to, and applied no more stringent than, the process, strategies, evidentiary standards, and other factors used to apply these NQTLs to medical/surgical benefits in the same benefits classification
- The specific findings and conclusions reached by the health plan, including if the plan is in compliance with these rules

Mental Health Parity Transparency

- If the applicable agency reviews the comparative analysis and determines that the plan is not in compliance:
  - The plan must specify the actions to be taken to comply and provide a new comparative analysis within 45 days that demonstrates compliance
  - Following the 45-day corrective action period, if the applicable agency makes a final determination that the plan is not in compliance, then not later than 7 days after such determination, it shall notify all individuals enrolled in the plan that the plan is not in compliance

Mental Health Parity Transparency

- Action Items:
  - Ensure that the company understands which plans and benefits must comply with these rules
    - Excepted benefits will not need to comply
  - For self-funded health plans, ensure that the TPA will conduct these tests
  - Be prepared to respond to a request

Reporting on Pharmacy Benefits and Drug Costs

- This is a new reporting requirement for health plans, in which reports are due to the Treasury/DOL/HHS
- The first report is due by December 27, 2021 and subsequent reports are due no later than June 1 of every subsequent year
- There are 10 items listed in the CAA that must be included in the report

Reporting on Pharmacy Benefits and Drug Costs

- #1 — the beginning and end dates of the plan year
- #2 — the number of enrollees
- #3 — each State in which the plan is offered
- #4 — the 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan and the total number of paid claims for each such drug
- #5 — the 50 most costly prescription drugs with respect to the plan by total annual spending and the annual amount spent by the plan for each such drug

Reporting on Pharmacy Benefits and Drug Costs

- #6 — the 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is subject of the report, and, for each such drug, the change in amounts expended by the plan in each such plan year

Reporting on Pharmacy Benefits and Drug Costs

- #7 – The total spending on health care services by such plan broken down by
  - (A) the type of costs, including: (i) hospital costs, (ii) health care provider and clinical costs, for primary care and specialty care separately; (iii) costs for prescription drugs, and (iv) other medical costs, including wellness services
  - (B) spending on prescription drugs by: (i) the health plan and (ii) the enrollees
- #8 — The average monthly premium (A) paid by the employer and (b) paid by enrollees

Reporting on Pharmacy Benefits and Drug Costs

- #9 — Any impact on premiums by rebates, fees and other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed to enrollees, including: (A) the amounts so paid for each therapeutic class of drugs and (B) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year
- #10 — Any reduction in premiums and out-of-pocket costs associated with rebates, fees and or other remuneration described in #9

Reporting on Pharmacy Benefits and Drug Costs

- Public Reporting — The CAA requires that HHS make available on its website a report on prescription drug reimbursements under health plan, prescription drug pricing trends, and the contribution of prescription drug costs to premium increases or decreases under such plans
- This information is to be aggregated in a way that no plan specific information will be made public
- The initial report is to be issued no later than 18 months after the first informational report is submitted (i.e., 18 months after December 27, 2021)

Reporting on Pharmacy Benefits and Drug Costs

- Action Items:
  - Sponsors need to amend agreements to ensure that this information will be prepared and the reports will be provided
  - Agreements with TPAs and PBMs must be revised for these new rules
  - Understand how rebates and other similar money is used by the plan (point of sale rebates? rebates returned to the plan sponsor and used to reduce overall plan costs?)
- This is important data and should be used in all RFPs in the future as a way to benchmark and manage drug costs
- This data should help a plan sponsor understand how much extra money is being received by the PBMs with regards to the drugs dispensed under the plan

Summary of Certain CAA Effective Dates

- Currently Effective
  - Permissive FSA amendments
  - Removal of gag clauses
- February 10, 2021: Mental health parity transparency (GHPs must make information available upon request)
- December 27, 2021:
  - Disclosure requirements for compensation paid to brokers and consultants of certain ERISA plans
  - Reporting on pharmacy benefits and drug costs
- Plan Years beginning on or after January 1, 2022
  - No surprise billing requirements
  - ID Card changes
  - Advanced EOBs
  - Continuity of care rules for transitional periods
  - Price comparison tool
  - Accuracy of provider directory information

CAA – Some of the Forthcoming Agency Rules and Guidance

- 7/1/21: Certain no surprise billing rules
- 10/1/21: Rules regarding the audit process of qualifying payment amounts (no surprise billing)
- 12/27/21:
  - IDR process regulations
  - Notice and rules regarding air ambulance report submissions
- 1/1/22: Proposed rule implementing protections against provider discrimination (final rule to follow – not later than 6 months following the end of the 60-day comment period)
- 6/27/2022: Mental health parity transparency rules

Additional Transparency Rules — Not in the CAA

- It should be noted that at the end of 2020, the DOL and Treasury issued final rules on price transparency
- These are FINAL and not part of the CAA
- One set of the rules become effective as of January 1, 2022 (Negotiated Rates) with the other set becoming effective January 1, 2023 (Cost-Sharing)
- These rules apply to GHPs, but exclude grandfathered health plans, plans providing only excepted benefits, account-based plans (such as HRAs) and retiree-only health plans

Additional Transparency Rules — Not in the CAA

- These new rules include a safe harbor for sponsors of fully insured plans if there is a written agreement with the health insurer to provide this information
- There is not any similar relief for self-funded GHPs

Additional Transparency Rules — Not in the CAA

Public Disclosure of Negotiated Rates and Allowed Amounts

- For plan years beginning on and after January 1, 2022, GHPs are required to publish three machine readable files:
  - File #1—In-network provider negotiated rates
  - File #2—Data outlining the historical allowed amounts for covered items and services provided by OON providers
  - File #3—Pricing information on prescription drugs

Additional Transparency Rules — Not in the CAA

Cost-Sharing Disclosure

- For plan years beginning on and after January 1, 2023, the GHP must disclose to enrollees, through an online tool, personalized cost sharing information
- It must include the negotiated rates for 500 services listed in the regulations
- For plan years beginning on and after January 1, 2024, it must include all covered items and services

Additional Transparency Rules — Not in the CAA

Cost-Sharing Disclosure

- The information that must be included in this tool is detailed in the new rules and includes things such as the following:
  - The estimated cost-sharing liability
  - The amount the enrollee has accrued towards the GHP's deductible and OOPM
  - The negotiated rate for an in-network provider
  - The maximum amount the GHP will pay an OON provider for the service or item
  - The items and services for which the disclosed information covers (this can be an issue for bundled services)
  - Additional information not listed on this slide

Additional Transparency Rules — Not in the CAA

- These are significant rules that will change health care pricing forever
- We will provide more information on these rules in February
- Plan sponsors must:
  - Have a basic understanding of these rules
  - Understand which GHPs will be subject to these rules
  - Create a budget for compliance with these rules
  - Assign people in the company's organization to be tasked with ensuring the requirements of these rules are met

Retirement Plan Provisions under the CAA

- Qualified Disaster-related Relief Provisions
  - Qualified Disaster Distributions
  - Disaster-related Plan Loans
  - Return of Withdrawals for Home Purchase/Construction
- New COVID-19 Pandemic Related Relief Provisions
  - Partial Plan Termination Temporary Relief
  - In-Service Distributions During Working Retirement
  - Expansion of CRDs to Money Purchase Pension Plans
  - Relief for Qualified Future Transfers

Qualified Disasters

- The CAA provides certain relief for "Qualified Disasters."
- A Qualified Disaster is a major disaster that:
  - is declared by the President during the period beginning on January 1, 2020, and ending on February 25, 2021,
  - but which must have occurred on or after December 28, 2019, and on or before December 27, 2020, and during the period specified by the Federal Emergency Management Agency as the period during which the disaster occurred (the "Incident Period").

Qualified Disasters

- A major disaster covered by this relief includes the wildfires and hurricanes that occurred in 2020.
- A major disaster does not include a disaster declared only because of a COVID-19 incident.
- Participants are "Qualified Individuals" and may afford themselves of the relief if (i) their principal place of abode is in a Qualified Disaster area; and (ii) they suffered an economic loss from the Qualified Disaster.

Qualified Disaster Distributions

- The CAA provides for a tax-favored withdrawal referred to as a Qualified Disaster Distribution ("QDD").
- A QDD is a distribution from an eligible retirement plan made on and after the first day of the Incident Period and prior to June 25, 2021 to a Qualified Individual.
- The plan administrator likely can rely on the participant's certification that he or she is a Qualified Individual.

Qualified Disaster Distributions

- QDDs are subject to the following tax benefits:
  - The 10% early distribution excise tax is not applicable.
  - Income tax is spread ratably over three years unless the participant elects otherwise.
  - It is not subject to 20% mandatory withholding and the 402(f) tax notice requirements.
- QDDs cannot in the aggregate exceed $100,000.
  - May be multiple distributions.
  - The aggregate limit applies to all plans of the employer and its controlled group.
  - The limit applies separately in the case of a participant who experiences multiple qualified disasters.

Qualified Disaster Distributions

- The participant may repay the QDD at any time during the three-year period beginning on the day after the distribution date.
  - May make one or more repayments (not in excess of aggregate amount of each QDD).
  - Repayments may be made to any eligible retirement plan that accepts rollover contributions.

Qualified Disaster Distributions

- This is an optional provision.
- It may be added as a special withdrawal right but even if not added to the plan, a Qualified Individual may elect the tax treatment to other permissible plan distributions.

Qualified Disaster Loans

- The CAA provides for Qualified Disaster Loans.
- These are loans made to Qualified Individuals during the period December 27, 2020 to June 25, 2021.
- Qualified Disaster Loans have a maximum loan limit to the lesser of:
  - (1) $100,000 (increased from $50,000); or
  - (2) 100% (increased from 50%) of the participant's vested benefit.

Qualified Disaster Loans

- The CAA also permits plans to suspend loan repayments due between the first day of the Incident Period and 180 days after the end of the Incident Period.
- The suspension period can be up until the later of:
  - (i) one year after the date the payment was due; or
  - (ii) June 25, 2021.
- Interest must continue to accrue on the balance, and the payments must be adjusted to account for the suspension when they resume.

Return of Withdrawals for Home Purchase/Construction

- The CAA permits a plan sponsor to allow certain individuals who took hardship withdrawals from their plan accounts for a home purchase or construction to repay the funds.
- Specifically, any individual who received a "Qualified Distribution" may make one or more contributions (not to exceed the amount of the Qualified Distribution), during the "Applicable Period," to an eligible retirement plan, provided:
  - The individual is a participant/beneficiary under such eligible retirement plan; and
  - A rollover contribution of such distribution can be made to such eligible retirement plan pursuant to Internal Revenue Code ("Code") section 402(c), 403(a)(4), 403(b)(8), or 408(d)(3) (as applicable).
- The tax treatment of these repayments is the same as previously described for repayments of Qualified Disaster Distributions.

Return of Withdrawals for Home Purchase/Construction

- For these purposes –
  - A "Qualified Distribution" means any distribution:
    - described in Code section 401(k)(2)(B)(i)(IV), 403(b)(7)(A)(i)(V), 403(b)(11)(B), or 72(t)(2)(F);
    - which was to be used to purchase or construct a principal residence in a Qualified Disaster area, but which was not so used on account of the Qualified Disaster with respect to such area; and
    - which was received during the period beginning on the date which is 180 days before the first day of the Incident Period of such Qualified Disaster and ending on the date which is 30 days after the last day of such Incident Period.
  - The "Applicable Period" means the period beginning on the first day of the Incident Period of such Qualified Disaster and ending June 25, 2021.

Plan Amendment Deadline

- The plan amendment deadline for adopting any of these optional disaster-related relief provisions is:
  - the last day of the first plan year beginning on or after January 1, 2022 (December 31, 2022 for calendar year plans); or
  - the last day of the first plan year beginning on or after January 1, 2024 (for governmental plans).

Partial Plan Termination Temporary Relief

- The CAA provides temporary relief from the partial plan termination rules under Code section 411(d)(3) for turnover due to the COVID-19 pandemic.
- Specifically, a retirement plan will not be treated as having incurred a partial plan termination for any plan year that includes the period beginning March 13, 2020 and ending March 31, 2021, provided that the number of active participants covered under the retirement plan on March 31, 2021 is at least 80 percent of the number of active participants on March 13, 2020.
- This means a plan sponsor can avoid a partial plan termination, and 100% vesting, if its participant workforce is substantially re-established by March 31, 2021.

In-Service Distributions During Working Retirement

- The CAA lowers the in-service distribution age during working retirement under Code section 401(a)(36) for certain employees.
- Specifically, the in-service distribution age during working retirement has been lowered from age 59½ to age 55 for multiemployer pension plans covering building and construction industry employees, with respect to participants in the plan on or before April 30, 2013, if:
  - the plan's trust was in existence prior to January 1, 1970; and
  - before December 31, 2011, at a time when the plan provided that in-service distributions during working retirement may be made to an employee who has attained age 55, the plan received at least one favorable determination letter from the Internal Revenue Service.
- This means certain building and construction trade workers can continue to work and receive retirement benefits.

Expansion of CRDs to Money Purchase Pension Plans

- The CCA clarifies that coronavirus-related distributions ("CRDs"), previously provided by the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), include in-service withdrawals from money purchase pension plans.
- This is effective as if included in the CARES Act at enactment on March 27, 2020.

Relief from Qualified Future Transfers

- The CAA permits employers who had previously elected to make a "qualified future transfer" under Code section 420(f) to terminate those elections.
- Code section 420(f) generally permits a sponsor of an overfunded defined benefit pension plan to transfer surplus assets to fund up to 10 years of future retiree medical benefits in a Code section 401(h) account.
- Elections to terminate a qualified future transfer must be made before December 31, 2021.

Plan Sponsor Decisions

- Decisions for the plan sponsor are:
  - Decide if any of the optional disaster-related relief provisions will be adopted.
  - Plan amendments required, especially if a sponsor wants to add as a special withdrawal right.
  - Given the immediate effective date and limited availability, sponsors will want to reach out to their third-party administrator soon, and work with them to ensure proper tracking of applicable limits, recontributions and other rules related to such disaster-related relief provisions.
  - Determine if the COVID-19 related relief provisions apply to their plans.
  - Prepare appropriate communications to impacted participants.

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