In this Special Edition

After a somewhat torturous journey to becoming law, HR 133, *Consolidated Appropriations Act of 2021*, was signed late on December 27, 2020. It is a massive piece of legislation covering much ground. Notably, it includes both coronavirus relief as well as the appropriation portion to keep the government running for the next fiscal year. The law includes direct economic impact payments of $600/each as well as temporary extension of supplemental unemployment relief. Further, it includes Paycheck Protection Program (PPP) loan expansion.

Following is a brief summary of some of the employee benefit aspects of the law. Additional information will be forth coming as the law is interpreted and further defined through regulation. It is also very possible that additional legislation will be enacted in the next legislative session.

Cafeteria Plan Relief

The law provides temporary relief for cafeteria plans, medical flexible spending accounts (FSA) and dependent care FSA as follows:

Status-change

The law continues the relaxation of status changes events initially allowed by Notice 2020-29 (see prior ***Benefit Beat*** article). As a reminder, generally cafeteria plan mid-year status changes are only permitted upon the occurrence of certain specifically delineated events.

Carry-over

The law allows a temporary carry-over from the 2020 plan year to the 2021 plan year and a carry-over from the 2021 plan year to the 2022 plan year of unused balances. Medical FSAs are already permitted to include a carry-over feature.

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This temporary relief is particularly relevant for dependent care FSAs. As a reminder, dependent care FSAs generally, cannot allow a carry-over. The law does not appear to include a limit on the amount of carry-over.

Grace periods

The law allows the medical FSA and dependent care FSA to expand the otherwise available 2 ½ month grace period to a 12-month grace period.

Note: allowing the carry-over or grace period expansion impacts HSA-eligibility.

Spend down feature

The law allows a medical FSA to allow a spend down feature similar to that which is available to dependent care FSAs. Effectively, a plan could permit an individual who has terminated employment to spend down any unused medical FSA.

Dependent care FSA age limit

The dependent care assistance program relaxes the age 13 limit specifically for children who would otherwise have aged out during the 2020-2021 plan year.

An employer is not required to permit any of these changes. If the employer does intend to allow some or all of these changes, the plan must be amended by the end of the plan year following the plan year to which it takes effect.

Educational Assistance

As a reminder, the CARES Act allows Internal Revenue Code Section 127, *Educational Assistance Plans* to reimburse student loans. An education assistance program can reimburse up to $5,250. The student loan portion of the reimbursement was to expire December 31, 2020. This has been extended through 2025.

Retirement Plan Issues

Partial Plan Termination

One of the concerns caused by the coronavirus precipitated layoffs has been partial retirement plan termination. If a qualified retirement plan loses 20% or more of its participants, the plan is deemed partially terminated, meaning that all participants become immediately fully vested. This law temporarily relaxes this standard by providing for any qualified retirement plan year occurring between March 13, 2020 and March 31, 2021 will not be deemed partially terminated as long as the number of participants in the plan on March 31, 2021 is at least 80% of the number of participants in the plan on March 13, 2020.

Qualified Disaster Relief

The law exempts certain retirement plan distributions from the 10% early withdrawal penalty.

Temporary Tax Relief

Emergency paid sick and family leave

As a reminder, the Families First Coronavirus Relief Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security (CARES) Act provided temporary emergency paid sick leave and emergency family leave. These provisions expire December 31, 2020. The law does not extend these leave laws, but it does extend the availability of the tax credit through March 31, 2021. Effectively, if an employer subject to the emergency paid sick leave and family leave laws chooses to continue to make leave available through March 31, 2021, the employer can continue to take the available tax credit for it. The law does not require the employer to make an additional allotment of leave available.

Paid family and medical leave tax credit

The Tax Cuts and Jobs Act enacted in December 2017 added a new tax credit for wages paid to qualifying employees during any period in which an employee is absent from work due to a family and medical leave event. An employer is eligible for a general business tax credit under Code Section 45S if it has a separate written policy in place that allows all qualifying full-time employees a minimum of two weeks of annual paid family and medical

leave. The policy must also allow non-full time qualifying employees a comparable amount of leave on a pro rata basis. Important to note that this credit is available to an employer without regard to whether it is subject to the federal Family and Medical Leave Act (FMLA), as long as the employer maintains the written policy that meets the wage payment criteria. This tax credit has been extended through 2025.

Business meals

The employer deduction for business meals which currently stands at 50% is increased to 100% for business meals provided by restaurants through the period 2022. The intent of this provision is to support the use of restaurants.

Medical expenses

The individual medical deduction level of 7.5% is made permanent.

Surprise Medical Bills

This law would restrict surprise medical bills primarily from emergency room services, certain out-of-network services for which the individual does not have an opportunity to accept or decline and for air ambulance services. Notably, the law does not apply to ground ambulance services.

Notice

A provider shall provide on the date the appointment is made a written notice in paper or electronic form, as selected by the insured that clearly states that consent to receive such items and services from such non-participating provider is optional and that the insured may instead seek care from a participating provider. The notice must indicate that the provider is a non-participating provider under the insured's health plan and include a good faith estimated amount that such provider may charge the insured for such items and services.

Identification cards

A plan or issuer shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants, beneficiaries, or enrollees in the plan or coverage the following:

- Any deductible applicable to such plan or coverage.
- Any out-of-pocket maximum limitation applicable to such plan or coverage.
- A telephone number and Internet website address through which such individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with such plan or coverage for furnishing items and services under such plan or coverage.

External review

The law requires that surprise medical bills challenges be included in the external review requirements imposed by the Affordable Care Act.

Arbitration

Effectively this law prohibits providers from balance billing patients. Providers can engage in a baseball-style arbitration to resolve any disputes with insurers.

A non-participating provider that receives an initial payment or a notice of denial of payment from the plan regarding a claim for payment for such item or service, may initiate open negotiations between such provider and plan for purposes of determining an amount agreed on by such provider and plan for payment (including any cost-sharing) for such item or service.

If the open negotiation fails to result in an agreed upon amount for payment, the non-participating provider or the plan may initiate the independent dispute resolution process with respect to such item or service.

Transparency on Pricing (So-called gag clauses)

A health insurance issuer offering group or individual health insurance coverage may not enter into an 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 restrict a health plan from providing provider-

specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan.

Service Provider Fee Disclosure

The law will require fee disclosure by health plan agents and brokers similar to those that apply to retirement plan fee disclosures. Effectively, if a plan service provider receives $1,000 or more in direct or indirect compensation annually, this must be disclosed. Applies to contracts executed on or after the one year anniversary of the law. Effectively beginning in 2022.

Pharmacy Disclosure

The law will require certain pharmacy disclosures as follows. Plans or issuers must provide to the Departments of Health and Human Services, Treasury and Labor the following information:

- The beginning and end dates of the plan year.
- The number of enrollees.
- Each State in which the plan or coverage is offered.
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan or coverage, and the total number of paid claims for each such drug.
- The 50 most costly prescription drugs with respect to the plan or coverage by total annual spending, and the annual amount spent by the plan or coverage for each such drug.
- The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.
- Total spending on health care services by such group health plan or health insurance coverage.
- The average monthly premium paid by employers on behalf of enrollees, as applicable and paid by enrollees.
- Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators.
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration.

The report is due one year after the date of enactment of the Consolidated Appropriations Act 2021, and not later than June 1 of each year thereafter.

Not later than 18 months after the report is required, HHS will make available on its website a report on prescription drug reimbursements, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.

Mental Health Parity

A group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes non-quantitative treatment limitations (NQTLs) on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs.

The comparative analyses shall contain the following information:

- The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
- The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
- The evidentiary standards used for the factors. Every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental

health or substance use disorder benefits and medical or surgical benefits.

- The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.
- The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses that indicate that the plan or coverage is or is not in compliance.

The Departments of Health and Human Services (HHS), Treasury and Labor can request these comparative analyses. The Department of HHS will annually make available a mental health compliance document to assist plans in satisfaction of the obligations of the mental health parity law.

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