Client Update
01/26/2021

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Key Employee Benefits Provisions in the CAA
Part 1: Health and Welfare Plan Provisions

Intended to provide relief to individuals and businesses facing economic hardship due to the outbreak, the Consolidated Appropriations Act of 2021 (the "Act") contains numerous employee benefit and executive compensation provisions, including extensive requirements for group health plans and health insurers addressing surprise medical billing. In a series of three articles, we will summarize the key changes implemented by the Act that may directly or indirectly affect employee benefit plans.

This article discusses the numerous provisions in the Act that affect health and welfare benefit plans. Part 2 and Part 3 of this article series will review the fringe benefits and retirement plan provisions affected by the Act.

There are extensive group health plan requirements regarding surprise medical billing. Notably, many of the requirements are companion amendments to the Employee Retirement Income Security Act of 1974 ("ERISA"), the Internal Revenue Code (the "Code"), and the Public Health Service Act ("PHSA").

Surprise Medical Billing Provisions *(Div. BB, Title I, §§ 102, 105.)*

Title I of the Act includes several provisions intended to regulate surprise medical billing—including companion provisions for emergency and air ambulance services. Under the Act, plans or insurers that cover emergency room services in a hospital or independent freestanding emergency department must offer certain services:

- Without requiring preauthorization determinations; and
- Regardless of whether a health provider that delivers the services is a participating provider in the plan's network or the emergency facility.

For services provided by out-of-network providers, the Act requires, in pertinent part, that:

- No preauthorization requirements be imposed.
- The services be furnished without coverage limits or requirements that are more stringent than for emergency services delivered by participating providers.
- Any cost-sharing requirements are not greater than those for services provided by in-network providers.
- The plan or insurer must send the provider, within 30 days of receiving the provider's bill for services an initial payment or notice that it is denying payment—and must then pay the remainder of the bill (that is, out-of-network rate minus cost-sharing) consistent with timing rules described in the Act.

The Act's surprise billing provisions also address coverage of non-emergency services performed by non-participating providers at certain facilities. In such instances, a plan or insurer may not impose cost-sharing requirements on participants that exceed the cost-sharing requirements that would apply if a participating provider had delivered the service. As in the emergency services context, the plan or insurer must make an initial payment to the provider (or furnish a denial notice regarding the service) within 30 calendar days of receiving the provider's bill. The balance of the bill must then be paid, consistent with the Act's timing requirements. In addition, any cost-sharing payments made by a participant for these services must count toward the plan's in-network deductible and out-of-pocket maximums as if the services were furnished by a participating provider.

Out-of-Network Rate Determinations: Independent Dispute Resolution Process *(Div. BB, Title I, § 103.)*

The Act includes open negotiation and independent dispute resolution ("IDR") procedures for use by plans or insurers and non-participating providers to determine the amount that will be paid for a provided service. The parties can participate in a 30-day open negotiation process that begins on the day the provider receives the plan's initial payment (or denial notice) regarding the service. If the plan/insurer and provider cannot agree to a payment amount during the 30-day open negotiation period, either party may then invoke the IDR process by providing notice to the other party and to the Department of Health and Human Services ("HHS"). If this occurs, a "certified IDR entity" will determine the payment amount for the service. Under implementing guidance concerning the IDR process (to be

issued in the future), there will be criteria for jointly determining the payment amounts as to multiple disputed items (for example, if services are related to treatment for a similar condition).

Implementing guidance also will address procedures for:

- Certifying and selecting IDR entities (for example, whether the entity can demonstrate fiscal integrity). (Similar certification requirements regarding financial well-being currently exist under the Internal Revenue Service's rules for certified professional employer organizations ("CPEOs")).
- Ensuring that there is a sufficient number of IDR entities.
- Allowing plans/insurers and non-participating providers to jointly select an IDR entity to review disputed services.

To date, the requirements for certification as a "certified IDR entity" are unclear, and no implementation guidance regarding the IDR process has been issued.

Health Plan Advance Estimates *(Div. BB, Title I, § 111-112.)*

Beginning in 2022, if a participant schedules a health care service to be performed by a provider with sufficient advance notice, the provider must:

- Ask whether the individual is enrolled in a group health plan and whether the individual plans to have the requested service covered under the plan.
- Provide a "good faith estimate" in clear and understandable language of the expected charges for the service, and services reasonably expected to be offered in conjunction with the service, to the individual's plan or insurer.

The provider's notice to the plan must include expected billing and diagnostic codes for the service.

For plan years beginning in 2022 and after, group health plans and insurers that receive the provider's notice regarding a participant's scheduled service must provide the participant with a notice—in most cases within one business day of receiving the provider's notice that contains specified coverage information. For instance, the plan's notice to a participant must provide:

- Whether the provider is a participating provider as to the scheduled service and if so, the contracted rate for the service based on relevant billing and diagnostic codes.
- A good faith estimate of how much the health plan will pay for the scheduled services.

External Review and Surprise Medical Billing *(Div. BB, Title I, § 110.)*

The Affordable Care Act ("ACA") expanded the Department of Labor's ("DOL's") claim procedure requirement to include extensive external review provisions for group health plans and health insurers (PHSA § 2719(b) (42 U.S.C. § 300gg-19(b)). On or before January 1, 2022, the DOL, HHS, and Treasury Departments must require plans and insurers to apply these external review procedures regarding benefit denials relating to the Act's surprise medical billing provisions.

Transparency Regarding Deductibles and Out-of-Pocket Limits *(Div. BB, Title I, § 107.)*

The Act requires additional disclosures to inform participants of applicable health plan cost-sharing requirements. Specifically, plans and insurers must provide the following information, in clear terms, on any physical or electronic plan-related identification card issued to participants:

- Any deductibles and out-of-pocket maximum limits applicable to the plan or coverage.
- A telephone number and website address through which participants can obtain plan-related information (for example, in-network hospitals and urgent care facilities).

Continuity of Coverage Regarding Health Providers *(Div. BB, Title I, § 113.)*

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

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

These participants must be provided with an opportunity to inform the plan that they need such transitional care from the provider. The plan must permit participants to elect to continue receiving plan-covered benefits:

- Under the same terms and conditions that would have applied as to services that would have been covered, had the provider not been terminated from the network.
- Regarding the course of treatment delivered by the provider to the individual, as a continuing care patient for *up to a 90-day period* from when the plan's notice is furnished.

Health Plan Price Comparison Tool *(Div. BB, Title I, § 114.)*

The Act requires plans and insurers to provide price comparison tools by telephone and through the plan's website. The tool must permit plan participants to compare their portion of cost-sharing under the plan for particular services and items for the plan year, based on specific geographic regions and participating providers.

Prohibition on Pricing Information Gag Clauses *(Div. BB, Title II, §§ 201.)*

The Act prohibits "gag clauses" regarding price or quality information. Under this provision, group health plans and health insurers cannot enter into agreements with health providers or networks, third-party administrators ("TPAs"), or other service providers to directly or indirectly restrict the plan or insurer from:

- Furnishing provider-specific cost or quality of care information to referring providers, plan sponsors, or participants or beneficiaries.
- Electronically accessing de-identified claims information for a participant or beneficiary on request and consistent with:
    - The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
    - The Genetic Information Nondiscrimination Act of 2008 ("GINA"); and
    - The Americans with Disabilities Act of 1990 ("ADA").
- Sharing the above-referenced information (or directing it to be shared) with HIPAA business associates.

Note that health providers and service providers may place *reasonable* restrictions on this information.

In addition, the gag clause provision requires group health plans to submit an annual attestation stating that the plan or insurer is in compliance with the foregoing requirements.

Health FSA Carryovers; Post-Termination Reimbursements *(Div. EE, Title II, § 214.)*

Under the Act, for plan years ending in 2020, health flexible spending arrangements ("health FSAs") and dependent care FSAs may permit participants to carry over any unused amounts or contributions from the 2020 plan year to the plan year ending in 2021. These carryovers will be allowed under rules similar to the existing carryover rules for health FSAs. Likewise, health and dependent care FSAs with plan years ending in 2021 may permit participants to carryover unused amounts to plan years ending in 2022. For plan years ending in 2020 or 2021, health or dependent care FSAs with grace periods may extend the grace periods for these arrangements to 12 months after the end of the plan years.

A related provision under the Act addresses post-termination reimbursements from health FSAs. Specifically, health FSAs may permit employees who stop participating in the arrangements during 2020 or 2021 to continue receiving reimbursements from unused amounts through the end of the year in which the employee's participation ends. This provision:

- Includes any grace period (including as extended under the Act's 12-month grace period provision).

- Will apply rules similar to those for dependent care FSAs.

Another provision contains a carry-forward rule for dependents who aged out of a dependent care FSA during the COVID-19 pandemic.

State All Payer Claims Databases *(Div. BB, Title I, § 115.)*

The Act allows states to apply for a one-time grant to either establish or improve an existing State All Payer Claims Database. A State All Payer Claims Database is a database that may include medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers. The databases can be used for research or for quality improvement or cost-containment purposes. Each grant of $2,500,000 will be paid over three years. Within one year, the DOL must establish a standardized reporting format for group health plans to voluntarily report information collected from private and public payers.

Disclosure of Compensation for Brokers and Consultants to Health Plans and Individual Market Enrollees *(Div. BB, Title II, § 202.)*

The Act expands the ERISA Section 408(b)(2) service provider compensation disclosure rules to group health plans. The disclosure rules apply to any entity that expects to receive at least $1,000 in direct or indirect compensation for providing brokerage or consulting services to a group health plan. The service provider must provide the plan fiduciary with a description of the services to be provided and the type of compensation that it reasonably expects to receive before a service contract is entered into or renewed. The plan fiduciary should notify the DOL if a service provider fails to comply with the disclosure requirements.

Health insurers offering individual health insurance coverage must make similar disclosures to enrollees in the individual health insurance market. Specifically, they must disclose any direct or indirect compensation paid to an agent or broker associated with enrolling individuals in coverage. The information must be provided before the individual finalizes plan selection and in any enrollment confirmation notices.

The rules will apply to contracts executed after the one year anniversary of the Act's enactment date.

Nondiscrimination in Health Care Providers Under the ACA: Implementing Regulations *(Div. BB, Title I, § 108.)*

In 2010, the ACA included a provision prohibiting group health plans and health insurers that offer group or individual coverage from discriminating, with regard to participation under a plan or coverage, against any health provider that acts within the scope of its license or certification under applicable state law.

The Act requires the Departments to issue proposed regulations under PHSA Section 2706 on or before January 1, 2022. Following a 60-day comment period for the Departments' proposed regulations, the Act directs the Departments to finalize their regulations within six months of when the comment period closes.

Full Deduction for Business Meals (2021 and 2022) *(Div. EE, Title II, § 210.)*

As a general rule, the Code permits a maximum fifty percent (50%) deduction for otherwise allowable food and beverages expenses. However, for a limited time, the Act permits a full deduction for food or beverage expenses provided by a restaurant that are paid or incurred after December 31, 2020, and before January 1, 2023.

Contact

Reach out to Fraser Stryker's employee benefits & ERISA attorneys for further assistance.

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