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Happy New Employee Benefits Year: Stimulus Relief for 2021

Presented by:

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1

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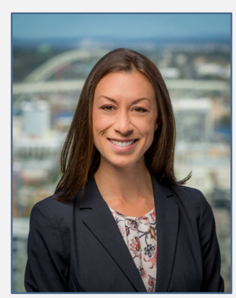

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2

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Agenda

- Brief overview of prior COVID-19 pandemic legislation, guidance, and relief
- Overview of new legislation relating to:
  - Retirement plans
  - Qualified educational assistance programs
  - Flexible spending account plans
  - Group health plans: networks & coverage
  - Group health plans: disclosure & reporting

3

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COVID-19 Legislation and Relief

4

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Prior COVID-19 Legislation and Relief

- IRS Notices relating to high deductible health plans (HDHPs) and tax filing deadlines
- Families First Coronavirus Response Act (FFCRA)
- Coronavirus Aid, Relief, and Economic Security Act (CARES Act)
- Outbreak Period deadline extension guidance jointly issued by DOL and IRS
- Relief on required ERISA notices under EBSA Disaster Relief Notice 2020-01 issued by DOL
- Cafeteria plan guidance issued by IRS
- Outbreak Period deadline extension guidance issued by HHS

5

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New Legislation: Consolidated Appropriations Act, 2021 (CAA)

- Massive year-end spending bill
- The most comprehensive single piece of legislation to impact group health plans since the Affordable Care Act (ACA)
- Includes the following items relating to employee benefits:
  - Special rules for retirement plans relating to partial terminations
  - Retirement plan disaster distributions and loan relief
  - Extension of special rules for educational assistance
  - Special rules for health and dependent care FSAs
  - “No Surprises Act” addressing billing practices and network coverage
  - Transparency and disclosure provisions
- Most provisions are optional
- Many provisions are available immediately

6

Retirement Plans

7

Partial Terminations

Regular Requirements	Prior Modifications or Relief
• A partial termination can occur when there has been a workforce reduction, shutdown of a worksite or division, general employee turnover due to adverse economic conditions, or other reasons that are not within the employer's control. • Generally, a 20% or greater turnover rate in an applicable period results in a partial termination, which requires full vesting of affected participants' account balances.	• No prior modifications or relief.

8

Partial Terminations Under CAA

NEW

- Partial terminations are determined based on the "applicable period," generally the plan year (PY).
- A plan is not treated as having a partial termination if the number of active participants on March 31, 2021 is at least 80% of the number of active participants on March 13, 2020.
- New provision applies to any PY that includes a date within the range March 13, 2020 to March 31, 2021.

9

Partial Terminations Under CAA (cont.)

NEW

- This provision provides relief for plans that had a reduction in active participants covered by the plan greater than 20% at the end of the PY and would otherwise experience a partial termination.

  Example:
  - Calendar year plan with a reduction greater than 20% at the end of 2020
  - If sufficient employees are rehired so that the number of plan participants on March 31, 2021 is at least 80% of the number on March 13, 2020, there is no partial termination for either PY.

10

Disaster Distributions and Loan Relief

Regular Requirements	Prior Modifications or Relief
• Distributions are generally included in income in the year of distribution; distributions are not generally permitted prior to age 59½; early distributions are subject to 10% penalty. • Loans are limited to 50% of vested account balance and must be repaid within 5 years (except primary residence loan).	• CARES Act provided distribution and loan relief for individuals affected by COVID-19 (expired). • Relief for prior year disasters (expired).

11

Disaster Distributions and Loan Relief Under CAA

- Qualified disasters:
  - "Incident period" for the disaster occurred between December 28, 2019 and date of enactment.
  - Disaster is declared between January 1, 2020 and 60 days after date of enactment.
  - Specifically excludes any disaster declared solely as a result of COVID-19.
- To qualify, the individual must have:
  - Lived in the disaster zone during any time during the "incident period," and
  - Sustained an economic loss due to the disaster.

NEW

12

Disaster Distributions and Loan Relief Under CAA (cont.)

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Distributions

- Permits "Qualified disaster distributions" of up to $100,000
  - Not subject to age 59½ restriction
  - Not subject to 10% penalty tax
  - Taxation spread over three years
  - Distribution may be repaid during three-year timeframe
- Certain hardship distributions previously made to purchase or construct a principal residence that were not used due to a qualified disaster may be repaid to a plan no later than 180 days after CAA enactment.

13

Disaster Distributions and Loan Relief Under CAA (cont.)

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Loan Relief

- Loan limit increased to 100% of account balance, up to $100,000.
- Loan payments due during incident period and up to 180 days after date of enactment may be delayed by one year.
- May disregard period of loan payment delay when calculating maximum five-year loan period.

14

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Implementation and Communication: Disaster Distributions and Loan Relief

- Disaster provisions are optional for qualified plans.
- Work with service providers and recordkeepers to implement decisions on whether to offer this relief and communicate availability to participants.
  - Issue updated SPD or SMM (ERISA plans)
- Plans may implement provisions administratively before formal amendment.
- Plan amendments are required by last day of plan year beginning on or after January 1, 2022.
  - December 31, 2022 for calendar-year plans

15

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Qualified Educational Assistance Programs

16

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Qualified Educational Assistance Programs

Regular Requirements	Prior Modifications or Relief
• Employers can provide tax-free educational assistance to employees under a qualified educational assistance program, up to $5,250 per calendar year. Educational assistance can include tuition, books, and fees and does not have to be work-related.	• The CARES Act temporarily expanded the definition of educational assistance benefits to include payments on a qualified education loan, allowing an individual's student loan repayments to be reimbursed or paid directly by an employer on a tax-favored basis. • The CARES Act provision expired January 1, 2021.

17

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Educational Assistance Under CAA

- The CARES Act temporary expanded definition of educational assistance benefits under Code §127 was extended for five years to apply to qualified education loan payments made before January 1, 2026.
- Annual combined limit of $5,250 for all qualified educational assistance, including qualified education loan repayment, still applies.
  - Example: Employee who receives $1,250 in qualified educational assistance during 2021 can only receive $4,000 in qualified education loan payment benefits in 2021.
- Still cannot offer employees a choice between educational assistance benefits and cash compensation.

NEW

18

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Implementation and Communication: Qualified Educational Assistance Programs

- Offering a qualified educational assistance program is optional, including whether to offer expanded educational assistance benefits.
- Work with service providers and recordkeepers to discuss decisions on whether to offer expanded benefits.
- Adopt/amend qualified educational assistance program.
- Communicate plan terms to employees.

19

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Flexible Spending Account Plans

20

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Flexible Spending Account (FSA) Carryover

Regular Requirements	Prior Modifications or Relief
• Health FSA: May allow carryover of unused balances up to $550 (indexed). • Dependent Care FSA: Carryover not permitted.	• No prior modifications or relief.

21

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FSA Carryover Under CAA

- Entire balance under Health FSAs and Dependent Care FSAs at the end of the 2020 PY may be carried over to 2021 PY.
- Entire balance under Health FSAs and Dependent Care FSAs at the end of the 2021 PY may be carried over to 2022 PY.
- Carryover does not reduce maximum salary contribution amount available for 2021 or 2022 PY.
- Rule that any carryover amount in full-purpose Health FSA can make employee ineligible to make HSA contributions for entire next plan year not changed.
  - Carryovers best for employers who do not sponsor HDHPs and HSAs.
  - But employee can avoid issue by declining the carryover amount or the plan can automatically convert carryover amount to limited-purpose health FSA.

NEW

22

FSA Grace Period

Regular Requirements	Prior Modifications or Relief
• Health FSA: May provide for grace period of up to 2 months and 15 days after close of PY. • Health FSA may not have both a grace period and a carryover. • Dependent Care FSA: May provide grace period for 2 months and 15 days after close of PY.	• For unused amounts in Health FSA *or* Dependent Care FSA at end of a grace period or PY ending in 2020, plan may permit employees to apply amounts to medical care or dependent care expenses, respectively, incurred through 12/31/2020.

23

FSA Grace Period Under CAA

- Health FSAs and Dependent Care FSAs may provide a 12-month (instead of a 2½-month) grace period at the end of the 2020 PY.
  - All unused 2020 PY FSA amounts available for claims incurred during the subsequent 12 months.
- Health FSAs and Dependent Care FSAs may also provide a 12-month grace period at the end of the 2021 PY.
- Plans cannot offer both the CAA carryover and grace period provisions.

NEW

24

FSA Grace Period Under CAA (cont.)

- Caution: Adding the CAA extended grace period provision to a Health FSA may create problems with eligibility to make HSA contributions.
  - Under current guidance, participants cannot waive the grace period, and it must apply uniformly to all participants.
  - Can move balance to limited-purpose Health FSA for grace period to avoid this issue.

NEW

25

FSA Spend Down

Regular Requirements	Prior Modifications or Relief
• Health FSA: Spend down not permitted. • Dependent Care FSA: Spend down feature permitted under existing rules.	• No prior modifications or relief.

26

Health FSA Spend Down Under CAA

- Health FSAs can add spend-down feature.
  - Allows employees terminated in calendar year 2020 or 2021 to spend down balances after termination for remainder of the PY of termination.
  - Appears to allow terminated employees to spend down contributed balances without paying COBRA premiums.
- Caution: Adding spend down provision to general use Health FSA precludes an individual from making or receiving HSA contributions during extended period.
  - Guidance needed: Unclear if an individual can decline spend down coverage.

NEW

27

Dependent Care FSA Definition of "Child"

Regular Requirements	Prior Modifications or Relief
• Dependent Care FSA: Your qualifying child who is your dependent and who was under age 13 when the care was provided.	• No prior modifications or relief.

28

Definition of "Child" Under CAA

- Maximum age of qualifying child increases from 13 to 14, with some limitations.
- Reimbursement of expenses for qualifying child who turned 13 during 2020 is permitted for the remainder of the 2020 PY, and for 2021:
  - With respect to unused amounts carried over from 2020 into 2021, *and*
  - Only until the child turns 14.
- Applies only if the open enrollment period ended before 1/31/2020.

NEW

29

FSA Election Changes

Regular Requirements	Prior Modifications or Relief
• Health FSA: Mid-year elections permitted only for qualified change in status event. • Dependent Care FSA: Same as above.	• Notice 2020-29 provided for prospective mid-year elections for health plans, Health FSAs, and Dependent Care FSAs.

30

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FSA Election Changes Under CAA

- Prospective mid-year election changes may be allowed without a qualified change in status event.
- Provisions only apply to FSAs (not to medical, dental, and/or vision elections).
- Guidance needed: It appears FSAs can permit employees who have not elected FSA contributions for 2021 to make new elections mid-year (similar to rule under prior guidance).

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31

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Implementation and Communication: Flexible Spending Account Plans

- Review available options for changes to FSAs.
- Confirm TPA's ability to administer new provisions and any costs associated with the changes.
- Communicate changes to employees.
- Adopt plan amendment(s) no later than the last day of the first calendar year beginning after the PY in which the amendment is effective.
  - e.g., no later than 12/31/2021 for an amendment that provides for carryover of 2020 amounts into 2021 from a calendar year FSA.

32

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Group Health Plans

33

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Group Health Plans: Overview

- No Surprises Act
  - Network billing and coverage
  - Reporting obligations
  - Provider and facility requirements
- Transparency and disclosure requirements
- Most provisions effective for plan years on or after January 1, 2022

34

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Group Health Plans: Overview

Regular Requirements	Prior Modifications or Relief
• Some state and federal laws already apply to insurers and providers (e.g., contracting, patient protections). • Numerous existing disclosure obligations for plans (e.g., SPDs, SMMs, SARs, EOB, and claims determinations). • Other reporting obligations (e.g., Form 5500, W-2s).	Transparency in coverage regulations take effect in 2022-2024: • Internet-based, self-service tool providing estimates of cost-sharing, in-network and out-of-network rates, and requirements before coverage is available. • Publicly posted, machine-readable files that illustrate in-network rates, out-of-network rates, and prescription drug prices. • Various disclosures on EOBs.

35

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Group Health Plans: Overview

- Highlight 16 primary provisions from the CAA that impose new obligations on group health plans (GHPs), issuers, or providers.
- Begin with earliest effective provision, then proceed through three categories:
  - Networks & Coverage
  - Contracting & Provider Billing
  - Disclosure & Reporting

36

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Earliest Effective Provision Under CAA

#1 – Mental Health Parity Compliance

- If plan has nonquantitative treatment limitations (NQTLs) on MH/SUD benefits, must perform and document comparative analysis of NQTLs.
- Must make available upon request to state or federal agencies:
  - The NQTL comparative analysis; and
  - Additional information about plan and coverage.
- Effective 45 days from enactment.
- Tri-agencies required to develop reporting process for this data to be submitted for evaluation.

2020 Self-Compliance Tool for MHPAEA available from the DOL at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

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37

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Networks and Coverage Under CAA

#2 – Network Coverage

- GHPs must generally provide coverage to patients by applying in-network cost shares when services are provided:
  - For emergency care in a hospital or emergency department (ED);
  - For services by an out-of-network provider at an in-network facility; and
  - By an out-of-network air ambulance service.
- Generally, no prior authorization requirement is permitted for emergency care or services by out-of-network provider at in-network facility.

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38

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Networks and Coverage Under CAA (cont.)

#3 – Prohibition Against Balance Billing

- Certain out-of-network providers and facilities and air ambulance services are prohibited from balance billing patients, except with notice and consent.

#4 – “Inadvertent” Out-of-Network Coverage

- Services received out-of-network due to inaccurate directory information must be covered at in-network cost sharing level.

#5 – External Review

- Existing external review process will be available for surprise billing and air ambulance provisions.

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39

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Networks and Coverage Under CAA (cont.)

#6 – Continuity of Care

- GHPs must:
  - Notify patients when terminating contract with a provider or facility for in-network care;
  - Allow patients to request transitional care with that provider or facility; and
  - Extend the same level of coverage with that provider or facility to “continuing patients” for up to 90 days.
- Providers and facilities must accept GHP’s in-network level payment and continue to follow policies and procedures of the GHP for continuing patients.

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40

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Contracting and Provider Billing Under CAA

#7 – Prompt Payment

- GHPs must pay or issue notice of denial within 30 days for:
  - Out-of-network emergency care in a hospital or ED;
  - Services by an out-of-network provider at an in-network facility; and
  - Services from an out-of-network air ambulance service.

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41

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Contracting and Provider Billing Under CAA (cont.)

#8 – Reimbursement Negotiations

- GHPs are required to negotiate reimbursement rates with certain out-of-network providers; new arbitration process to be available.

#9 – Prohibition Against Gag Clauses

- May not enter into agreements with providers, networks, or TPAs that would bar:
  - Disclosure of provider-specific cost and quality information;
  - Access to de-identified claims data; or
  - Sharing PHI with a business associate.
- Must submit attestation of compliance annually.

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42

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Disclosure and Reporting Under CAA

#10 – Network Directories

- GHPs must:
  - Provide a provider directory on a public website listing network health care providers and facilities;
  - Verify accuracy of the directory no less frequently than every 90 days and remove or update listings timely; and
  - Respond timely to and document inquiries about directories from enrollees.

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43

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Disclosure and Reporting Under CAA (cont.)

#11 – Billing Protections Disclosure

- Include information about surprise billing and balance billing patient protections on EOBs and plan websites.

#12 – Price Comparison Tool

- GHPs must offer price comparisons by telephone and must maintain website that provides price comparisons for items and services (including amount of cost sharing).

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44

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Disclosure and Reporting Under CAA (cont.)

#13 – Advance EOBs

- GHPs must provide advance explanation of benefits (cost estimates) based on billing and diagnostic codes reported by providers.
- Requires specific information including:
  - Network affiliation of provider;
  - Good faith estimate of cost to patient; and
  - Reference to applicable medical management techniques.

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45

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Disclosure and Reporting Under CAA (cont.)

#14 – I.D. Cards Disclosures

- Insurance I.D. cards must include:
  - Any applicable deductible;
  - Any applicable out-of-pocket maximum limit; and
  - Contact information for consumer assistance.

#15 – Broker and Consultant Compensation

- Must disclose to GHPs at the time of contracting the services to be provided and compensation to be received (direct or indirect).

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46

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Disclosure and Reporting Under CAA (cont.)

#16 – Pharmacy and Medical Cost Reporting

- Must report to Departments:
  - Extensive pharmacy claims information;
  - Cost breakdown for various service categories;
  - Premium information; and
  - Impact of Rx rebates on cost and coverage.
- Reporting will be due annually by June 1.
- However, first report to be due before 12/27/21.

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47

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Implementation and Communication: Group Health Plans

- Assess compliance for provisions taking effect soon:
  - NQTL comparative analysis and documentation;
  - Use of gag clauses in contracts; and
  - Pharmacy and medical cost reporting.
- Monitor forthcoming guidance.
- Make plans for implementation with insurers and TPAs prior to effective dates.

48

Future Developments in the New Year

49

When Does the Outbreak Period End?

- Outbreak Period began March 1, 2020 and was slated to end 60 days after the announced end of the COVID-19 emergency under DOL/IRS guidance.
- Authority of DOL/IRS to extend deadlines under ERISA §518 and Code §7508A(b) lasts for only one year. Does this mean:
  - The Outbreak Period ends on February 28?
  - The Outbreak Period continues, but individual deadline extensions expire on a rolling basis?
- Unclear whether agencies can extend the deadlines absent statutory authority.

50

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Future Developments in the New Year

- OCR/HHS proposed modifications to the HIPAA Privacy Rule.
- EEOC proposed new wellness rules under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).
- New final rules on employer shared responsibility and nondiscrimination requirements for integrated HRAs.
- Further regulatory guidance is expected.

51

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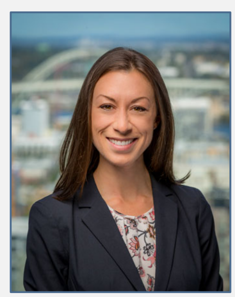
Questions?



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52

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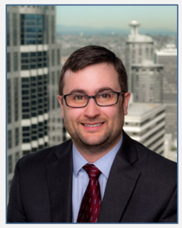
Additional EB Resources



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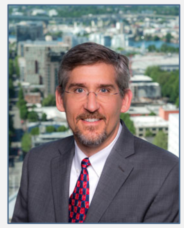

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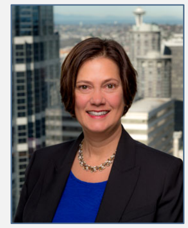

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53

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54