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Health and Welfare Plan Changes in the Consolidated Appropriations Act, 2021

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CHANGES FOR GROUP HEALTH PLANS

The protections for participants and their beneficiaries in the Patient Protection and Affordable Care Act[1] (the ''ACA'') were expanded by the Consolidated Appropriations Act, 2021[2] (the ''Act''). Some changes built on concepts in the ACA, some added additional reporting requirements for employers sponsoring group health plans, and others created opportunities for new entrepreneurs. Most of these changes for health plans will not be applicable until 2022, but the effective dates need to be watched now. Employers should start to prepare as this impacts the planning for 2022 which is commencing in the next few months.

The plan participant protections added by the Act were generally enacted similar to the way in which HIPAA's portability provisions were added in 1996 by adding parallel provisions to the Public Health Services Act[3] (PHSA), to the Employee Retirement Income Security Act[4] (ERISA) and to the I.R.C. The ACA changes were added to the PHSA and then incorporated by reference into the I.R.C. and ERISA. By enacting the changes in the three statutes, the changes cover most group health plan and insurance issuers and are further defined by regulations jointly issued by the three federal agencies charged with administering such laws, the Department of Health and Human Services (HHS) for the PHSA, the IRS for the I.R.C., and the U.S. Department of Labor (DOL) for ERISA (collectively the ''Tri-Agency(ies)''). Regulations issued by the Tri-Agencies on parallel statutory language is done via a coordinated process. So the rapid statutory deadlines on the issuance of the implementing regulations will present a challenge first for the Tri-Agency group working on the regulations and then for employers working toward compliance, unless transitional relief is provided. Employers will need to watch for the guidance.

Prevention of Surprise Billing for Patients Seeking Care from an Emergency Room or Free Standing Emergency Care Facility

When an individual goes to an emergency department, there is no way for the individual to control whether the health care providers or the related facility services and their health care providers are in-network. This new provision is targeted to reduce the unexpected bills following seeking emergency care services. The Act adds ERISA §716 and I.R.C. §9816 which addresses care for emergencies up until the individual is stabilized. Care provided by an out-of-network provider, provided after an individual is stabilized, is only covered if certain requirements are satisfied. The surprise billing provisions add more

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[1] Pub. L. No. 111-148.

[2] Pub. L. No. 116-260.

[3] Pub. L. No. 78-410, 42 U.S.C. ch. 6A §201 *et seq.*

[4] Pub. L. No. 93-406, 29 U.S.C. ch. 18 §1001 *et seq.*

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protections for participants than the similar provisions enacted in the ACA with respect to emergency room service payment.

The Act is intended to prevent surprise bills to patients seeking care in emergency rooms or freestanding emergency care facilities, and the provisions protecting access to pediatrician and obstetrician and gynecologist care as primary care providers. Such provisions each expand on similar existing provisions in the ACA as it is incorporated into the PHSA, but the Act puts the expanded provisions into ERISA and the I.R.C. directly. Thus, these expanded protections would survive even if the ACA were overturned in the courts.

The Act's changes are intended to prevent surprise bills from emergency department services and require that such services be provided without requiring any prior authorization, that the services be paid without considering the in-network or out-of-network status of the health care provider and be paid so that if the service provider is not part of the in-network providers so that the cost sharing will not be greater for the participant in the plan than if the services had been provided by an in-network provider or facility. Balance billing is limited by the Act's changes.

The Act requires plans to pay such claims initially within 30 days of submission by the health care provider,[5] and ultimately paid as soon as possible after the amount of the payment is determined through the new process. So claims administrators will need to monitor the date on which such emergency claim was received and when the initial and final payments are due in addition to the ERISA claim and appeal decision timing deadlines. Regulations to implement this new provision, including determining the ''qualified payment'' amount for claims, requires information to be shared with the health care provider in processing these claims, and a process to be used are to be issued by July 1, 2021.

The ''qualified payment'' amount is calculated by each plan based on the generally contracted rates recognized by the plan considering all plans of such sponsor for such item or service provided by a provider of the same or similar specialty in the geographic region in which the item or service was provided. This is based on the plans' claim pricing on January 31, 2019, with adjustment for the geographic area, and for the consumer price index for all urban consumers over 2019, 2020, and 2021. This amount for each item or service will be the ''qualifying amount'' for an item furnished in 2022. For years after 2022, the amount will be adjusted by the percentage increase in the consumer price index over the previous year. There are special rules for new plans and for newly covered items and services.[6]

By October 1, 2021, HHS, in cooperation with the DOL and the IRS, is directed to establish a new method to determine what constitutes a ''qualified payment'' for Emergency Department or Free-Standing Emergency facility services considering the size of the plan and the geographic location of the provider.[7]

For services and items furnished by out-of-network providers where there is no state law determining the payment rate, then the out-of-network provider and the plan may negotiate in ''open negotiations'' as to the amount to be paid. If the amount to be paid is reached by agreement of the parties, then that is the amount paid. If such open negotiations do not determine the amount to be paid,[8] then either the emergency room facility or department, or the plan may request to enter the independent dispute resolution (IDR) process operated by a certified IDR entity which shall determine the amount to be paid. See the discussion of the IDR process below.

The Act restricts such emergency service providers from balance billing a participant in excess of the participant's cost sharing amount under the group health plan. Such prohibition is effective for plan years beginning on or after January 1, 2022.

The Act also requires out-of-network providers to provide notices to the plan participants in advance of providing services, beyond services to stabilize the patient in the emergency, regarding their status as out-of-network provider, and the good faith estimate of the costs of the services to the participant, and a list of participating providers at the facility that could provide the services and whether prior authorization is required for any of the items or services. The individual must consent to be treated by a non-participating provider or facility after receiving the notice. Coordination regarding reporting of violations involves the Tri-Agency group identifying patterns of noncompliance by health care providers with the notice and prohibition on balance billing. The complaint and enforcement process for the emergency room/facility surprise billing also applies with respect to surprise air ambulance billing.[9]

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[5] ERISA §716(b)(1)(C); I.R.C. §9816(b)(1)(C); PHSA §2799A-1(a)(1)(C).

[6] ERISA §716(a)(3)(C)(ii), ERISA §716(a)(3)(E(ii); I.R.C. §9816(a)(3)(C)(ii), §9816(a)(3)(E)(ii), PHSA §2799A-1.

[7] PHSA §2799A-1(a)(2).

[8] ERISA §716(a)(3)(K); I.R.C. §9816(a)(3)(K); PHSA §2799A-1(a)(3)(K).

[9] Act Division BB, §102 (amending the PHSA to add ''Part E-Health Care Provider Requirements, PHSA §2799B-2'').

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Persons seeking emergency health care services should expect additional notices when the Act's provisions are effective as part of the care process.

Surprise Air Ambulance Billing

The Act amends ERISA and the I.R.C. to make changes intended to prevent surprise bills from air ambulance services and requires that such services be provided without requiring any prior authorization.

Such services shall be paid without considering the in-network or out-of-network status of the health care provider and shall be paid by the plan even if the service provider is not part of the in-network providers, so the cost sharing for the participant will not be greater than if the services had been provided by an in-network provider.

An out-of-network air ambulance claim must count against the in-network deductibles and cost sharing limits for the participant.

Such a claim by an out-of-network air ambulance provider is submitted and must initially be paid in part or the claim denied within 30 days of receiving such claim. After the initial payment, the group health plan and air ambulance provider are to enter open negotiations regarding the out-of network rate to be paid for the claim. If after the 30-day open negotiation period commences, no agreement is reached, then either the plan or the health care provider can request that the claim be sent to an IDR process to resolve the difference. The IDR process is described below and it is adopted for both the emergency department and free standing emergency facility claims as well as the air ambulance claims.[10] The out-of-network rate is either the rate set by state law, the rate agreed upon by the plan and the health care provider, or if there is no agreement, then the rate set by the IDR process. This will provide a new challenge for claims administrators and group health plan administrators actuaries to project pricing under the new regime for pricing and the claim payment. New IDR process service providers will be needed for such services and such new vendors will need to comply with the yet to be issued guidelines to be a certified IDR process service provider.

Claim administrators will need to monitor the date on which such emergency claim was received and when the initial and final payments are due in addition to the ERISA claim and appeal decision timing deadlines.

The enforcement of the protections related to air ambulance services billing will be subject to a same coordinated complaint and enforcement as applies to the emergency room or free-standing emergency department services.[11]

Participants or beneficiaries receiving air ambulance services which are paid for by a group health plan on or after January 1, 2022, should not be held liable for any amount in excess of their cost sharing limits under their group health plan (deductible, out of pocket maximum, coinsurance or copayments) from a non-network air ambulance service provider.[12]

A group health plan is required to report to the IRS, DOL, and HHS for two years after the final regulations implementing the air ambulance provisions of the Act by the deadline tied to such regulations issuance, particular data and information regarding the claims data for each air ambulance use considering five factors. Plan sponsors should work with their vendors to verify their vendors will capture the required data.

Enforcement of No Balance Billing for Emergency Room or Freestanding Emergency Facility Out-of-Network Services

In addition to mandating that patients be provided notice regarding the prohibition on balance billing by emergency departments or freestanding emergency facilities by such health care providers, the Act amends ERISA and adds §522 giving the DOL the authority to investigate and pursue patterns of abuse on compliance with the balance billing prohibition it notes in reports from HHS and the states. The enforcement efforts will be coordinated between the agencies. A new complaint process to handle these complaints will be established no later than January 1, 2022, for receipt of complaints, transmitting such complaints to states or HHS for potential enforcement.[13]

Additional Patient Protections – Access to Pediatric Care and Obstetrical and Gynecological Care

Direct access to pediatricians, obstetricians, and gynecologists as an individual's primary care provider is now part of ERISA and the I.R.C. and no longer part of the addition to the PHSA ACA provisions. So these protections should survive even if someone success-

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[10] ERISA §716, §717; I.R.C. §9816, §9817; PHSA §2799A-1, §2799A-3.

[11] Act Division BB, Title I §105(a)(2) (adding ERISA §717; I.R.C. §9817; PHSA §2799A-1).

[12] Act Division BB, Title I §105(b) (adding PHSA §2799A-5).

[13] Act Division BB, Title I §104(b) (adding ERISA §522).

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fully challenges the constitutionality of the ACA and the ACA is overturned.[14]

IDR Procedures for Determining Out-of-Network Rates to Be Paid by Group Health Plans for Air Ambulance Services and Emergency Room/ Facility Pricing

For 2022 and beyond, an IDR process that will be regulated by the HHS, DOL, and IRS will determine out-of-network rates for services from a nonparticipating provider or nonparticipating facility for service rendered to a participant or beneficiary of a group health plan. After an outof-network health care provider or facility receives an initial payment or a notice of denial of payment on a claim as an out-of-network provider, such provider or facility or the group health plan shall have 30 days in which to engage in open negotiations regarding payment and any cost sharing. If the open negotiations do not result in an agreement by the last day of the open negotiation period, then any of the parties may, within four days after the open negotiation process ends, initiate the IDR process to resolve the issues with respect to the claims. Thus, a new player will be involved in the claim process, the IDR service provider. The IDR process provider then steps in to determine the amount to be paid on the claim. Once the IDR process provider determines the amount required to be paid on the disputed claim, the plan must pay such amount within 30 days of such determination. The IDR process provider shall determine the allocation of its fees amongst the respective parties to the dispute.

Because the IDR process is only dealing with the amount paid for a claim, some may think it does not interact with the ERISA claim process, but since ERISA's claim regulations consider a claim denied if all or any part of the claim submitted is not approved, the determination of the amount to be paid under the IDR process will need to consider how it impacts the claim denial process, unless other guidance is provided exempting the amount of the payment under the IDR process as exempt from the ERISA claim and appeal process by relying on the no balance billing provisions added to the PHSA. Such balance billing prohibition is intended to limit the individual's responsibility.

By December 27, 2021, HHS, DOL, and the IRS shall issue regulations defining one IDR process to which a group health plan can submit disputes regarding the payments to out-of-network providers and facilities. The HHS, DOL, and IRS will develop the process to certify entities to be IDR service providers. Such certifications shall last for five years, but may be revoked for a pattern or practice of noncompliance with any of the requirements.[15]

New Transparency Requirement on Group Health Plan Identification Cards

Effective for plan years beginning on or after January 1, 2022, group health plan identification cards must include the plan in-network and out-of-network deductibles, out-of-pocket maximums, and a telephone number and internet website address through which the individual may seek consumer assistance information such as information related to which hospitals and urgent care centers have a contractual relationship with the plan. Employers planning for the 2022 plan year, will need to work with the administrative service providers to identify their capabilities in this area, particularly in situations where there may be more than one group of preferred or tiers of providers. For some plans using multiple specialty providers, this may require creating a plan website that integrates with the various specialty providers in use.[16]

Continuity of Care

A participant or beneficiary of a plan qualifies as a continuing care patient if he or she is receiving care from a network provider for (1) a serious and complex condition, (2) is undergoing a course of institutional or inpatient care from a provider or facility, (3) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of post-operative care with respect to a surgery, (4) is pregnant and undergoing a course of treatment for the pregnancy, or (5) is or was determined to be terminally ill and is receiving treatment for such illness from a provider or facility, and such provider or facility's contract to be a network provider terminates or expires for any reason other than fraud by such provider or facility. A continuing care patient facing a contract termination of his health care provider is mandated to be provided continuing care. The plan is required to meet all of the following requirements with respect to a person entitled to continuing care:

1. The group health plan must notify each individual enrolled under the plan who is one of a continuing care patient as being protected for continuing care at the time the provider or facili-

[14] ERISA §722; I.R.C. §9822; PHSA §2799A-2.

[15] ERISA §717(b); I.R.C. §9817(b); PHSA §2799A-2.

[16] Act Division BB, Title I §107 (adding ERISA §716(e)).

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ty's contract terminates and the plan must tell such enrolled individual of his or her right to elect continued transitional care from such provider or facility.

2. The group health plan shall provide such an individual with an opportunity to notify the plan or insurer of the individual's need for transitional care.

3. The group health plan must permit the individual to elect to continue to have the benefits provided under such plan or such coverage under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under such plan had the provider or facility's contract not terminated.

Such transitional coverage shall continue beginning on the date on which the individual receives notice of the contract termination and shall continue until the earlier of the 90 days after the individual's receipt of such notice, or the date on which such individual is no longer qualified as a continuing care patient under the definition above with respect to that health care provider or facility.[17]

The Act also requires the health care provider caring for the continuing care patient to accept payment from such plan for services and items furnished to such continuing care patient as payment in full for such items and services and to maintaining compliance with all policies, procedures, and quality standards imposed by the plan.[18]

These new protections for continuing care patients are effective for the first plan year beginning on or after January 1, 2022.[19]

New Reporting Requirements for Group Health Plans

State All Payer Database Reporting

Litigation has debated whether states can mandate group health plans subject to ERISA to report to state all payer databases. ERISA plans have disputed such requirements in order to avoid being required to report to multiple states in multiple formats utilizing ERISA's preemption.[20] The Act responds to these competing interests by requiring the Secretary of Labor no later than December 27, 2021, to establish a standardized reporting format for voluntary reporting by a group health plan to a state All Payer Claims Database of medical , pharmacy, and dental claims. Such reporting can also include eligibility and provider files. The Act authorizes an advisory committee to be formed to assist the Secretary.[21]

Air Ambulance Service Reporting Requirement

After December 31 of the first calendar year after final regulations are issued regarding reporting on air ambulance services, group health plans and health insurers will be required to report to the DOL, HHS, and IRS on claims data for air ambulance services. The report will require specified details on the types of care provided, emergent or non-emergent use of air ambulances, types of aircraft, claims, and other details. This reporting is initially required for a window period.[22]

Brokers and Consultants to ERISA Group Health Plans Required to Disclose Direct and Indirect Compensation to Plan

In 2012, retirement plan service providers were required to disclose the direct and indirect compensation they received as the result of services to the plan to increase the transparency regarding the fees related to retirement plans, but the regulations did not extend to health plans. The Act extends similar requirements to health plan service providers such as brokers and consultants. Brokerage services and consulting services are drafted broadly. In order for the payment of fees to brokers and consultants related to health plans, the brokers and consultants must disclose the fees and commissions they will either receive directly from the plan or indirectly as the result of their relationship to the plan to the responsible fiduciary to the health plan. Direct compensation that is reasonably expected to exceed $1,000 for the provision of brokerage or consulting fees and any nonmonetary compensation of $250 or more (e.g., free tickets to an entertainment event) must be discloses if they exceed $250 during the term of the contract. Indirect compensation is anything paid from any source other than the group health plan or plan sponsor, or the covered service provider or its affiliate, except when the indirect compensation is received in connection with service performed under a contract or arrangement with a subcontractor. It extends to commissions, overrides and persisting overrides that may be received as the result of renewals of contracts, or the volume of renewals of a type of contract.

Brokers, consultants, and service providers to group health plans must disclose such fees to the re-

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[17] Act Division BB, Title I §113(c) (adding ERISA §718; I.R.C. §9818; PHSA §2799A-3).

[18] Act Division BB, Title 1; PHSA §2799B-8.

[19] ERISA §718; I.R.C. §9818; PHSA §2799A-3.

[20] *See Gobeille v. Liberty Mutual Insurance Company,* 577 U.S. 312, 136 S. Ct. 936, 194 L. Ed. 2d 20 (2016) (preempting such a state database law mandating provision of data in its format).

[21] Act Division BB, Title I §115 (adding ERISA §735).

[22] ERISA §723; I.R.C. §9823; PHSA §2799A-5.

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sponsible fiduciary for the group health plan (the person authorized to sign for the group health plan) beginning on and after the date the new requirements become applicable on December 27, 2021. If a service provider fails to make the required disclosure, the responsible fiduciary for the group health plan is required to notify the service provider of its failure and permit it 90 days to provide the correct disclosure. If the service provider refuses to provide the disclosure or if it fails to provide the disclosure, then the responsible plan fiduciary must report the service provider to the DOL, and if the required disclosure relates to future services, the responsible plan fiduciary is required to terminate the relationship with the service provider.

While the statute contains a general date on which the requirements become applicable, it also grants the DOL the ability to provide transition rules and further definie the requirements under the regulations that are to be issued by December 27, 2021. Health insurance issuers are required to report. Group health plan contracts executed prior to December 27, 2021, are not required to comply with these disclosure requirements for such contract; however, nothing exempts such contract's subsequent renewals from the disclosure requirement. This may provide an incentive for some group health plan service providers to complete the contracting process prior to December 27, 2021, to delay the disclosures for some contracts.

Responsible plan fiduciaries for group health plans may want to begin with taking an inventory of all of the service providers of the group health plan to identify from whom disclosures will be required. After an inventory of service providers is developed, a process by which disclosures can be reviewed annually to ensure all of the required disclosure elements are contained in any disclosure should be developed so that the responsible plan fiduciary can assess its vendor compliance, track follow up requests for disclosures, and fulfill obligations to report omissions as required to the DOL.[23] After the fee disclosure regulations[24] mandating disclosure of retirement plan fees became effective, DOL audits regularly asked to see proof of the plan fiduciary's review of such disclosure and determination that the fees were reasonable. A process for documenting the health plan fee disclosures, reviewing such disclosures, and determining the reasonableness of the fees in the disclosure should be implemented and documented.

Mental Health and Substance Use Disorder Benefits Analysis Reporting

The Secretary of Treasury, Labor, and HHS are directed to issue a compliance program guidance document to help improve compliance with the mental health parity and substance use disorder protections under the Mental Health Parity and Addiction Equity Act. Such document shall provide de-identified examples of previous findings of compliance and noncompliance with non-quantitative treatment limitations, deficient information disclosures, and descriptions of violations discovered in investigations.

For any group health plan that imposes nonquantitative treatment limitations (e.g., preauthorization, medical necessity, or step therapy) on mental health or substance use disorder benefits, the Act mandates that beginning on February 10, 2021, such group health plan must perform a comparative analyses on the mental health and substance use disorder benefits as compared to the medical and surgical benefits. Such comparative analysis and additional data must be available to the DOL, IRS, or HHS upon request, and must contain specific information. Such information submitted to one of the regulating agencies under the newly defined process shall not be subject to disclosure under §552 of title 5 of the U.S. Code, the Freedom of Information Act. The comparative analysis must be provided to the applicable federal agency upon request and must include significant additional information regarding plan terms and how they operate. If this information is requested, the plan sponsor must provide it. If the agency determines the plan is not in compliance, the plan must respond within 45 days of such determination with a comparative analysis that demonstrates the plan's compliance. If, after reviewing the corrective actions to be taken by the plan, the agency finds the plan is still not compliant, then the agency notifies all participants in the plan that the plan is not in compliance.[25]

Pharmacy Benefit and Drug Cost Reporting and Other Reporting Requirements

By December 27, 2021, and each June 1 thereafter, group health plans must submit to the Secretary of Labor, Treasury, or HHS the following information on the group health plan's previous plan year. The data includes, the beginning and ending date of the plan year, the number of participants and beneficiaries, 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 and the total number of paid claims for each such drug, the 50 most costly prescription drugs for the plan by the total annual spent 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 for the plan year as compared to the preceding

[23] Act Division BB, Title II §202 (amending ERISA §408(b)(2)).

[24] 29 C.F.R. §2550.408b-2(c).

[25] Act Division BB, Title II §203 (amending ERISA §712(a)(6)-§712(8); I.R.C. §9812(a)(6)-§9812(8); PHSA §2726(a)(8).

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plan year, and for each such drug the change in the amounts expended by the plan or coverage in each such plan year. In addition to the above reporting on prescription drug costs, the new section also requires the following additional items be reported annually:

1. The total spending on health care services by the group health plan broken down by type of costs for:

a. hospital;

b. healthcare provider and clinical service costs for primary care and specialty care separately;

c. costs for prescription drugs by the health plan coverage and by the participants and beneficiaries;

2. The average monthly premium paid by the employer and by the participants and beneficiaries;

3. Any impact on the premiums from rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage or its administrators or service providers, and the amount so paid for each therapeutic class of drugs and the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates or other remuneration under the plan or coverage from drug manufacturers during the plan year; and

4. The group health plan must disclose any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration described in three above.

No later than 18 months following the first submission of the above report on December 27, 2021, the agencies shall provide a report on prescription drug costs in coverage in an aggregate manner and such other pricing trends.[26]

NEW DISCLOSURE REQUIREMENTS FOR GROUP HEALTH PLANS

Advance Explanation of Benefits (EOB) Requirements

Beginning with the first plan year beginning on or after January 1, 2022, when a non-network health care provider notifies a group health plan that a participant or beneficiary is scheduled to receive services, the plan must notify the participant no later than one business day after receiving such notice (such deadline varies depending upon the date on which the service is scheduled as compared to when the notice is received) in clear and understandable language, whether or not the health care provider or facility is an in-network provider for the plan.

In addition the advanced explanation of benefits to be provided to the participant or beneficiary must include all of the following information: (1) if the health care provider or facility is innetwork, the plan's notice must address for each of the items in the notice from the health care provider to the group health plan, the coverage with respect to the items or services, the contracted rate for such item or service, or (2) if the provider or facility is out-of-network for the plan, then the notice must provide (a) a good faith estimate for each item or service included in the notification received from the provider or facility, (b) a good faith estimate of the amount

The health plan is responsible for paying for the items or services in the estimate, (c) a good faith estimate of the amount of any cost sharing for which the participant or beneficiary would be responsible for such items or service (as of the date of the notification), (d) a good faith estimate of the amount that the participant or beneficiary has incurred toward meeting the limit of the financial responsibility toward the plan's cost sharing amounts, (e) if such items or services are subject to medical management such as concurrent review, pre-authorization or a step therapy or similar program, a disclaimer that coverage for such item or service is subject to such medical management technique.

For out-of-network providers or facilities, the advance EOB must also include a disclaimer that the information in the notice is only an estimate based on the items and services as reasonably expected at the time of the scheduling or request and that the items or services needed may be subject to change. The advance EOB must include any other information or disclaimer that the plan determines is appropriate and consistent.[27]

Pricing Comparison Tool for In-Network Services Required

For plan years beginning on or after January 1, 2022, a group health plan must offer price comparison guidance by telephone and on its website as a tool that permits price comparison under such plan to allow an enrolled individual to compare prices under the plan's coverage for different geographic regions for the plan year and to compare the amount of cost sharing the

[26] Act Division BB, Title II, §204 (adding ERISA §725; I.R.C. §9825).

[27] Act Division BB, Title I, §111 (adding ERISA §716(f); I.R.C. §9816(f); PHSA §2799A-1).

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individual would incur with respect to obtaining services or items from different in-network providers.

Employers preparing for vendor selection for their 2022 plan years should verify whether their group health plan's vendors will have the capability to fulfill this requirement for the 2022 plan year.[28]

Provider Directory Information Improvement

Effective for plan years beginning on or after January 1, 2022, group health plans will need to make a number of additional disclosures regarding the in-network providers used by the plan in addition to enhancing the website information and tools related to communicating with participants and beneficiaries regarding network providers to include an online directory, a verification process, and a mechanism to respond to participant inquiries.

The directory will need to go through a verification process, have an established database, include a disclosure regarding the date the directory was most recently published and direct the participant to contact the plan regarding the most information, and establish a protocol for an individual to contact the plan via telephone, internet, or electronic web based method on whether a provider or facility is contracted to be an in-network provider and the plan will respond no later than one business day after such contact is received in a response that is in a written, electronic, or print format with the format determined by the requesting individual. The plan must maintain a database of the in-network providers on its website and update such database within two business days of receiving a notice of change from a health care provider or facility. Each such change may trigger a continuity of care requirement discussed above and such changes must consider not only the impact on the directory, but also on the continuity of care coverage requirement and notices required. Record retention requirements apply to the communications from the plan to the individual participants regarding the status of health care providers or facilities.[29]

Health care providers and facilities are now required to put in place a business process to provide timely updates to provider directories at both the beginning of a network relationship and at the termination of such agreement. If a health care provider or facility bills a patient at an amount in excess of the in-network rate and at the individual pays the bill, the health care provider is required to repay the individual the amount paid in excess of the in-network rate for the services or treatment with interest at the rate specified by the HHS.[30]

CHANGES FOR FLEXIBLE SPENDING ACCOUNTS

Temporary Relief Provided from Flexible Spending Account "Use It or Lose It" Rule

As the last few days of the last plan year ending in 2020 come to a close, the Act makes a big change for all flexible spending accounts with a plan year ending in 2020 on or before December 31, 2020, to permit the unused amounts in such flexible spending accounts to carry over to the next plan year that ends in 2021. So if a calendar year health flexible spending account or dependent care flexible spending account had $800 remaining as of December 31, 2020, and had no further claims incurred before December 31, 2020 to use against such amounts, the plan may allow the participant to carryover such unused amounts into the 2021 plan year and use the carryover amounts to reimburse claims incurred in 2021.

While many plans have already had annual enrollment for calendar year plans for 2021 so that participants cannot change elections to address these new permissive carryovers, the Act also permits unused amounts from 2021 to be carried over to 2022. In addition, the Act permits employers to allow elections to be changed by participants during plan years ending in 2021 to alter the employee's contribution toward their 2021 health flexible spending account and dependent care flexible spending account. The Act did not alter the annual limitations on contributions to either health flexible spending accounts or dependent care flexible spending accounts to accommodate any amounts carried over. As a result, a participant, believing he or she had lost unused amounts from the 2020 plan year, may have elected to contribute the full amount (up to the limit) for 2021 and may need to make an election change for 2021 if the employee learns the employer is permitting the carryover of unused amounts from 2020, provided the employer also adopts the flexibility to make mid-year changes for the plan year ending in 2021.

For flexible spending account plan years ending in 2020 or 2021, if the flexible spending account uses grace periods, those grace periods for 2020 and 2021 may extend to up to 12 months following the end of

[28] Act Division BB, Title I, §114 (adding ERISA §719; I.R.C. §9819; PHSA §2799A-4).

[29] Act Division BB, Title I, §116 (adding ERISA §720, 42 U.S.C. §320B).

[30] Act Division BB, Title I, §116(e) (adding PHSA §2799B-9).

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the plan year. This means an employee with amounts in her health flexible spending account at December 31, 2020, if the employer adopts the extended grace period for up to all of 2021, may incur medical expenses at any time in 2021(during the 12 months following December 31, 2020 and use those expenses against the unused account balance at December 31, 2020).

The Act also provides a special rule for participants in a health care flexible spending account when the participant's employment terminates during the 2020 or 2021 calendar year which may permit submission of expenses incurred post-termination of employment against unused amounts in the participant's health care flexible spending account.

The Act also considered the fact that some dependents attained the limiting age for dependent care expense flexible spending account reimbursement during the pandemic by raising the limiting age from 13 years to 14 years for plan years for which their annual enrollment period was on or before January 31, 2020 and during which the dependent child attained the age of 13. So if an employee elected in annual enrollment during November of 2019 to contribute $5,000 to her dependent care flexible spending account and her child turned 13 in October of 2020, dependent care expenses for that child will not end when the child turned 13, but will continue to be eligible for submission and reimbursement until that child attains the age of 14 in October of 2021. This provides relief to individuals who did not incur expected dependent care expenses in 2020 when schools and dependent care services were closed and had a child attain the limiting age of 13 so that they can recover in the next following plan year for dependent care expenses incurred.[31]

[31] Act Division EE, §214.

OTHER FRINGE BENEFIT CHANGES —TEMPORARY EXPANSION OF EDUCATIONAL ASSISTANCE

Student Loan Repayment

The Act extended the period during which an employer may pay a portion of a student's loan under an educational assistance plan and not include such payment in the employee's taxable income to the extent, provided the payment does not exceed $5,250. This student loan payment provision was scheduled to expire on December 31, 2020. The Act extended this elective provision to amounts paid prior to January 1, 2026. This is not a required change, but a change an employer may consider adopting as part of its educational assistance plan or it could be adopted as the employer's educational assistance plan.[32]

CONCLUSION

The Act made significant changes to group health plans effective in 2021 and 2022, but due to the time line for health plan design changes and contracting with service providers, the changes should be considered by employers early in 2021. The changes may change plan costs driving changes in plan design and may require changes in plan service providers who will not be able to meet the new requirements. Group health plans need to consider the additional testing that will need to be prepared and ready to be submitted to the DOL upon request and the additional disclosure and reporting requirements as a matter of compliance and plan vendor or service provider selection.

[32] Act Division EE, §120.

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