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COVID-19 and Government Funding Legislation Signed into Law

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On December 27, 2020, the Consolidated Appropriations Act, 2021 was signed into law and provides for relief related to the COVID-19 pandemic, as well as government funding. The legislation is tremendous and totals more than 5,000 pages. There are many different issues addressed, but this article focuses on the following components of the law that affect health and welfare programs:

- Relief for Health FSAs and DCAPs
- No Surprise Billing
- Increased Transparency: Broker compensation, pharmacy cost and consumer transparency.
- Comparative Analysis Requirement of the nonquantitative treatment limitations ("NQTLs") used for medical and surgical benefits as compared to mental health and substance use disorder benefits to show compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA").
- Voluntary Extension of Families First Coronavirus Response Act ("FFCRA") Leave.

Below you will find additional detail on the above as well as other relevant aspects of the legislation.

Relief for Health FSAs and DCAPs

This relief comes very late in the year, which may pose significant administrative challenges. Employers will want to decide whether to allow any or all permissible changes and reach out to their FSA vendors.

Employers may, but are not required to, amend their cafeteria plan for any of the following:

- For a health FSA or DCAP:
  - **Carryover and grace period.** Participants (even in a DCAP) may carry over unlimited unused amounts (rather than up to $550) from the 2020 plan year to the 2021 plan year (and from the 2021

plan year to the 2022 plan year). Alternatively, employers may allow for a grace period for a plan year ending in 2020 or 2021 of up to 12 months after the end of such plan year (rather than 2½ months following the end of the plan year). Health savings account ("HSA") eligibility should be considered, if applicable. See note below.

- **Mid-year election changes.** For plan years that end in 2021, participants may make prospective election modifications without regard to any change in status.

- For a health FSA:
  - An employee who ceases participation in the plan during calendar year 2020 or 2021 may continue to receive reimbursements from unused amounts through the end of that plan year (including any grace period, taking into account any modification of a grace period permitted above).

- For a DCAP:
  - If a dependent child aged out during the pandemic, a participant can continue to receive reimbursements for such child's dependent care expenses for (1) the remainder of the plan year (if the enrollment period ended before January 31, 2020) and, to the extent a balance remains at the end of the plan year, (2) the following plan year until the child turns age 14 (but only with respect to the unused amount).

The plan must be amended no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective. For a January 1, 2020 to December 31, 2020 plan year, this means an amendment must be adopted no later than December 31, 2021. In addition, the plan must be operated in a manner consistent with the terms of such amendment during the period beginning on the effective date of the amendment and ending on the date the amendment is adopted.

Employers with qualified high deductible health plans ("HDHPs") tied to HSAs will need to work closely with their vendors to preserve HSA eligibility if adopting the carryover or grace period changes to the health FSA. If adopting a carryover, the rules permit a carryover from a traditional health FSA to an HSA-compatible health FSA for those electing the HDHP option in the subsequent year. However, similar treatment does not apply with respect to a grace period. Employers wishing to provide an HSA-compatible health FSA grace period will need to do so for all participants, not just those with HDHP coverage.

No Surprise Billing

Providers are generally barred from balance billing participants in a number of situations. Under the "No Surprises Act," effective for plan years beginning on or after January 1, 2022, participants pay in-network cost-sharing only for:

- Emergency services performed by an OON provider and/or at an OON facility and for post-stabilization care after an emergency if the patient cannot be moved;

- Non-emergency services performed by OON providers at in-network facilities (includes hospitals, ambulatory surgical centers, labs, radiology facilities and imaging centers); and

- Air ambulance services provided by OON providers.

Exception for Certain Non-Emergency Non-Ancillary Services Where Consent is Obtained

There is an exception to the prohibition against balance billing in the case of non-emergency services performed by an OON provider at certain in-network facilities.

Balance billing may be permissible when the provider provides the patient with oral and written notification at least 72 hours in advance of the appointment (or, for appointments made within the 72 hour window, on the same day on which the appointment is made) that includes the following:

- Notification of the provider's OON status;
- A statement that consent to receive services from an OON provider is optional and that the services may be received from a provider that can do so under the in-network cost structure;
- A good faith estimate of the amount the patient will be charged if he or she consents; and
- In the case of an OON facility, a list of any in-network providers at that facility who can provide the same item or service.

The patient must sign the notice in order to consent to the treatment by the OON provider and they must be provided a signed copy.

It is important to note that this exception does not apply to ancillary services provided by an OON provider at an in-network facility. Ancillary services include:

- items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- items and services provided by assistant surgeons, hospitalists and intensivists;
- diagnostic services (including radiology and laboratory services), unless exempt by future rulemaking; and
- items and services provided by non-participating providers if there are no participating providers at the same facility who can furnish such items or services.

Payment Amount

The plan must pay the OON provider as follows:

1. If the care is provided in a state that has a law in place that would apply on its own terms to determine the amount the plan would owe to the provider, the state law applies.
2. If the care is provided in a state that participates in the All-Payer Model Agreement, the amount the state approves under that system applies.
3. For care provided in states with no applicable rule and for air ambulance services disputes, the law prescribes a detailed process to determine the appropriate rate.

If the plan or insurer does not initially deny payment, it is required to remit a "qualifying payment amount" which is a median payment amount for the same or similar service the plan or insurer pays in the same insurance market and geographic area. There is a 30-day window for open negotiation.

After this period, if the payment amount is disputed, an Independent Dispute Resolution ("IDR") process kicks in. The IDR entity is required to pay based on:

- the level of training, experience and quality and outcomes measurements of the provider or facility;
- the provider/facilities market share in the geographic region in which the item or service was provided;

- the acuity of the individual receiving the item or service and the complexity of furnishing it;
- whether the providing facility is a teaching facility; and
- demonstrations by the parties of the extent to which they engaged in good faith efforts to enter into network agreements.

The IDR entity does not consider the amount the provider invoiced (billed charges), the provider's "usual and customary charges," or the amount public payors pay for the item or service in the course of making its determination.

The IDR entity's decision is final and generally may not be appealed. The "losing party" must pay the IDR fees/costs. HHS will assess a fee on both parties to the IDR to cover the agency's administrative costs.

The Departments are directed to issue regulations by July 1, 2021. States may impose other OON provider obligations that go above and beyond the federal statutory requirements.

Enforcement

States are charged with enforcing these federal requirements and providers are subject to penalties of up to $10,000 per violation unless they opt out, in which case HHS has enforcement authority. The DOL also has enforcement authority if it identifies patterns of balanced billing violations under a group health plan.

Transparency

Broker Compensation Transparency

Effective December 27, 2021, brokers and consultants of ERISA covered group health plans, regardless of size, must enter into a written contract with a responsible plan fiduciary which includes the following information:

- A description of the services to be provided;
- If applicable, a statement that the broker/consultant plans to offer fiduciary services to the plan;
- A description of all direct compensation the broker expects to receive (in the aggregate or by service);
- A description of all expected indirect compensation (including vendor incentive payments, a description of the arrangement under which the compensation is paid, the payer of the compensation, and any services for which the compensation will be received);
- Separately, any transaction-based compensation (e.g., commissions or finder's fees) for services and the payers and recipients of the compensation; and
- A description of any compensation the broker/consultant expects to receive in connection with the contract's termination (and how any prepaid amounts will be calculated and refunded upon termination).

The above applies when the broker or consultant expects to receive at least $1,000 in direct or indirect compensation (whether paid to the broker, an affiliate, or subcontractor) and should occur reasonably in advance of each contract date and renewal date. The definition of a broker or consultant for this purpose is broad and includes parties who are not considered traditional brokers/consultants (e.g., pharmacy benefit managers, wellness vendors, and third-party administrators).

Plan fiduciaries must report brokers/consultants to the DOL if they do not comply with these requirements.

Pharmacy Cost Transparency

Group health plans and insurers will be required to annually report to the Departments on their pharmacy benefits and costs multiple data points, including:

- Number of enrollees
- States in which the plan is offered
- 50 most common brand prescription drugs dispensed by pharmacies for claims under the plan and the total claims paid for each drug
- 50 most costly drugs by total annual spending and the annual amount spent for each of the 50 drugs
- 50 drugs with the greatest year-over-year cost increase for the plan and the change in amounts paid by the plan
- Total spending by the plan broken down by:
  - Types of cost (e.g., hospital, primary care, specialty care, provider and clinical service costs, prescription drugs, wellness) and
  - Plan and enrollee spending on prescription drugs
- Average monthly premiums paid by the employer and the enrollees
- Impact on premiums and out-of-pocket costs associated with rebates, fees or other payments by drug manufacturers to the plan or the plan's administrators, and certain specifics about those rebates/payments.

These new disclosure requirements go into effect December 27, 2021.

Consumer Transparency

The law provides the following additional transparency rules for insurers and plan sponsors of group health plans:

- **ID Cards.** The amount of the in-network and OON deductibles and the out-of-pocket maximums that apply to the plan and the plan telephone number and website contact information must be disclosed on any physical or electronic plan and on insurance identification cards.
- **EOB.** A requesting health care provider or facility or a requesting plan participant, beneficiary, or enrollee must be provided an explanation in advance that states whether the provider or facility is in-network for the item or service to be provided, the contracted rate for that item or service, and a description on how an individual may obtain the item or service from an in-network provider.
- **Price Comparison Guidance.** Price comparison guidance must be offered by telephone and made available on an internet website of the plan or issuer that enables an enrolled individual to compare the amount of cost sharing for which he or she would be responsible for paying with respect to the furnishing of specific items or services by any provider.
- **Provider Directories.** A process must be established to update and verify provider directory information at least every 90 days; respond within 1 day to enrollee questions about providers' in-network status; and maintain on a public website a database of all in-network providers and facilities and directory information for each of them. The plan must pay any extra costs that would be incurred by an enrollee that relies on any inaccurate directory information.

Third party payers cannot prohibit sharing of the above information/data with business associates in accordance with HIPAA standards.

These new disclosure requirements apply to plan years beginning on or after January 1, 2022. It is not clear how these transparency rules will overlap and coordinate with the recent transparency regulations finalized by the Departments. Further guidance in this area would be helpful.

Comparative Analysis Requirement

To comply with MHPAEA, a group health plan or issuer must perform and document comparative analyses of the design and application of NQTLs with the following information:

1. 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.

2. The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

3. The evidentiary standards used for the factors identified in (2), when applicable, provided that every factor must 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.

4. 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.

5. The specific findings and conclusions reached by the group health plan or issuer with respect to the health insurance coverage, including any results of the analyses described here that indicate that the plan or coverage is or is not in compliance.

Further guidance is expected.

Voluntary Extension of FFCRA Leave

The FFCRA provided new types of leave to employees of employers with less than 500 employees, applicable to leave taken between April 1, 2020, and December 31, 2020.

Under the new law, the FFCRA still sunsets on December 31, 2020. However, employers may voluntarily extend leave through March 31, 2021, and receive associated tax credits. This does not restart the clock on any employee's leave.

Self-employed individuals have the option to use prior year net earnings in determining average daily self-employment income.