More Changes for Employee Benefit Plans for 2021

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A number of significant new legal requirements for employee benefit plans were packed into the Consolidated Appropriations Act, 2021 (the "Act"), which passed on December 27, 2020. Additionally, new employee benefit plan design options were made available, under the guise of providing relief to individuals and businesses during the continuing COVID-19 pandemic. These new requirements and options also directly impact plan administration for qualified retirement plans and group health plans, and many of the new requirements will apply very soon, giving plan administrators little time to prepare.

This is the first of two summaries of the changes impacting employee benefit plans – focusing on group health plans. In the coming days, we will distribute a second summary of the changes impacting retirement plans.

"No Surprises Act"

Effective January 1, 2022, group health plans (including insured plans) must cover participants and beneficiaries for amounts up to the in-network rates, for: out-of-network emergency department services, air ambulance service providers, and out-of-network providers providing services in in-network facilities in certain non-emergency situations. In the event of a disagreement over the cost of a service, plans and providers may initiate negotiations within 30 days, and if they fail to agree may access independent dispute resolution (which will be detailed in a future regulation).

The "No Surprises Act" also includes a multitude of notice and disclosure obligations for group health plans. For example, plan administrators will need to:

- Provide insurance cards that disclose applicable deductible or out-of-pocket maximum limitations (as well as a telephone number and internet address for consumer questions);

Related Services

Employee Benefits

- Issue an advanced explanation of benefits for scheduled services;
- Notify continuing care patients of changes in network status;
- Maintain a cost-sharing price comparison tool via website (and offer price comparison guidance over the telephone); and
- Maintain up-to-date provider directories.

Plan Administrators have a brief window of time to negotiate new agreements with the health insurers and claims administrators to ensure these requirements are met.

Elimination of Gag Clauses on Price and Quality Information

Group health plans are prohibited from entering into a contract that directly or indirectly restricts the group health plan from engaging in certain acts. First, such agreements may not restrict the group health plan from providing provider-specific cost or quality of care information or data to: referring providers, the plan sponsor, participants, beneficiaries, or individuals otherwise eligible to become participants or beneficiaries. Second, such agreements may not restrict the group health plan from electronically accessing de-identified claims and encounter information. Finally, such agreements may not restrict the group health plan from sharing information or data with a HIPAA business associate. Group health plans will be required to annually submit an attestation of compliance with this requirement.

Plan administrators must review insurance and claims administration agreements for compliance with these new prohibitions, particularly existing limitations on audit rights, and must plan to meet the new attestation requirement.

Disclosure of Direct and Indirect Compensation for Brokers and Consultants

Starting December 27, 2021, group health plans must receive fee disclosures from certain service providers. Specifically, covered service providers must disclose direct and indirect compensation for contracts for insurance brokerage and consultation services (including plan design development or implementation, insurance selection, recordkeeping, and benefits administration selection) reasonably expected be at least $1,000 (adjusted for inflation). The disclosures must include items such as (but not limited to) a description of the services to be provided, a statement that the provider will (or reasonably expects to) provide fiduciary services, a description of the direct and indirect compensation, and a description of the compensation the service provider reasonably expects to receive upon termination.

Plan Administrators need to put in place a system to ensure that required disclosures are collected, and are reviewed when determining whether compensation is reasonable.

Mental Health Parity and Substance Use Disorder Benefits Transparency

Group health plans that provide both medical/surgical benefits and mental health or substance use disorder benefits must perform and document comparative analyses of the design and application of any non-quantitative treatment limitations ("NQTLs") under the plan. Examples of NQTLs include medical management standards based on medical necessity or appropriateness or whether a treatment is experimental or investigative, limitations with respect to prescription drug formulary design, use of fail-first or step therapy protocols, and network tier design. The analyses must include items such as (but not limited to) the specific plan or coverage terms or other relevant terms regarding the NQTLs, the factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits, and the evidentiary standards used for such factors.

These analyses must be available to the Department of Labor, Department of Health and Human Services, or an applicable state authority upon request as soon as February 10, 2021.

Although the February 10, 2021 deadline is unrealistic, Plan Administrators need to act quickly to obtain comparative NQTL analyses from their insurers and claims administrators.

Reporting on Pharmacy Benefits and Drug Costs

Group health plans (including insured plans) must submit an annual report to the Secretaries of Labor, Health and Human Services, and Treasury on the prescription drug benefits and costs offered by the plan. The report must include items such as (but not limited to) the states the plan or coverage is offered, the 50 brand prescription drug most frequently dispensed by pharmacies for claims paid by the plan or coverage and the total number of paid claims for each such drug, the 50 most costly prescription drugs with respect to the plan or coverage by total annual spending and the annual amount spent by the plan or coverage for each such drug, and any impact in premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or coverage. The reporting requirement will apply as of December 27, 2021 and must be updated by June 1 each year thereafter.

Plan Administrators have a brief window of time to negotiate new agreements with health insurers and claims administrators to ensure these reporting requirements are met.

Flexible Spending Account Options

Several provisions in the Act impact flexible spending accounts, all of which are optional at the election of the Plan Sponsor.

- A plan with a health flexible spending account ("HFSA") or a dependent care flexible spending account ("DFSA") may include a carry-over of any unused 2020 benefits or contributions remaining in any such flexible spending account to be available to provide benefits during the plan year ending in 2021. This same rule applies for plan years ending in 2021 as well (meaning an unlimited carry over to the plan year ending in 2022 is permitted).
- A plan with a HFSA or DFSA may extend the grace period ending in 2020 or 2021 up to 12 months after the end of such plan year. As a result, any amounts remaining in a HFSA or DFSA at the end of the 2020 or 2021 plan year are eligible for reimbursement for 12 months after the end of the plan year.

- A plan with a HFSA may permit a terminated employee during calendar year 2020 or 2021 to continue receiving reimbursement for covered expenses from unused benefits or contributions through the end of the plan year in which such participant terminated.
- A plan with a DFSA may permit participants whose qualifying child turned age 13 during the pandemic to continue to receive reimbursement for any covered dependent care expenses for the remainder of the plan year (should the enrollment period end before January 21, 2020) and the following plan year (to the extent a balance remains at the end of the incumbent plan year).
- For plan years ending in 2021, a plan with a HFSA or DFSA may permit an employee to change his or her election prospectively, without regard to any change in status.

Amendments for any of the preceding optional changes need not be made until the last day of the first calendar year after the end of the plan year in which the amendment is effective. However, to gain such relief, the plan must be operated consistent with the amendment that is adopted.

If any of these permitted changes are administratively adopted, the Plan Administrator needs to quickly communicate the changes to participants, despite the fact that the Plan amendment and Summary of Material Modifications may be generated later.

Please contact your Employee Benefits attorney at Butzel Long for help in ensuring compliance with these new legal requirements and permitted options.

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