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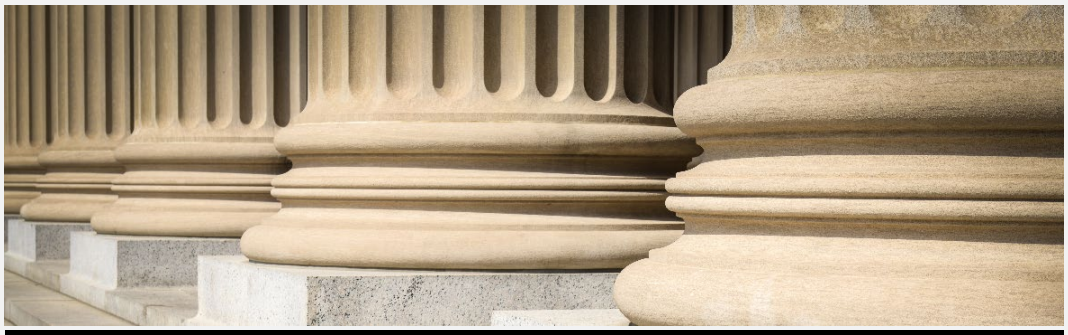

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Temporary Flexibility for Health and Dependent Care FSAs

Among the many ways the coronavirus pandemic has disrupted people's lives is the obstacles it has created for them to use up balances in their health and dependent

care FSAs. The Consolidated Appropriations Act (CAA), 2021, provides some help for 2020 and 2021.

No Limits on Mid-Year Election Changes

Under normal circumstances, employees must decide whether and how much to contribute to health and dependent care FSAs before the plan year begins, and once the plan year starts those elections can be changed only in limited circumstances. However, for plan years ending in 2021, plans can allow employees to make prospective changes to their elections without regard to whether they have experienced any change in status. Of course, the annual contribution limit of $2,750 for health FSAs and $5,000 for dependent care FSAs will continue to apply.

Enhanced Carryover and Grace Period Rules

Health FSAs and dependent care FSAs also are subject to the so-called "use-it-or-lose-it" rule. Basically, if an employee doesn't incur enough qualifying expenses during a plan year, any unused balance will be forfeited. Over the years the IRS has created two optional exceptions to this rule.

- The limited carry forward exception permits health FSAs (but not dependent care FSAs) to allow participants to carry forward unused balances of up to $550 from one plan year to the next.
- The grace period exception permits both health and dependent care FSAs to allow participants to use unused balances from one year during the first 2.5 months of the immediately following year.

For plan years ending in 2020, the CAA creates a special carry forward exception that permits both health and dependent care FSAs to allow unlimited carryovers of unused balances to the 2021 plan year. Likewise, for plan years ending in 2021 health and dependent care FSAs can allow unlimited carryovers of unused balances to the 2022 plan year.

Similarly, the CAA creates a special grace period exception for plan years ending in 2020 and 2021. Specifically, the CCA permits health and dependent care FSAs to extend their grace periods with respect to the 2020 and 2021 plan years for a full 12 months (i.e., the entire next plan year) instead of the usual 2.5-month limit.

Employers can choose to take advantage of either special rule, but not both. As discussed below plan amendments will be required, but not immediately. Employers that want to follow the special rules for the 2020 plan year should begin operating their plans accordingly and communicate the changes to participants.

Special Carry Forward Rule for Dependent Care FSAs

Dependent Care FSAs generally may only reimburse participants for certain "employment-related expenses," such as expenses incurred for the care of a "qualifying individual" while the participant was at work. A "qualifying individual" includes a participant's dependent who is not yet 13 years old. In the case of a participant's dependent who turns 13 (i.e., "ages out") during a Dependent Care FSA's plan year, only otherwise eligible expenses incurred before his or her birthday can be reimbursed.

Once the pandemic-related lockdowns started last year, it was not possible for many dependent care FSA participants to incur "employment-related expenses." This could have been the case because they were not working, or

because day care centers were closed, etc. That is why the special carryover and grace period rules discussed above are so important to so many Dependent Care FSA participants – i.e., so they can use the money they elected to contribute before the 2020 plan year begin and before they knew the pandemic would happen. But those rules don't help a participant if his or her "qualifying individual" turned 13 during 2020 because otherwise eligible expenses they incur now would not be reimbursable.

Thus, another special rule in the CAA provides relief for these participants. Specifically, for participants enrolled in a Dependent Care FSA during the 2020 plan year (or whatever the last plan year was for which the regular enrollment period ended on or before January 31, 2020), the age-out trigger is raised from 13 to 14 years old. That means these participants can seek reimbursement for otherwise qualifying expenses incurred during the 2020 plan year even after their dependent child turned 13. Additionally, if these participants still have unused balances from 2020, they can carry those amounts forward to the current plan year and use them to pay otherwise eligible expenses incurred until their dependent's 14th birthday.

Plan Amendments

All of these provisions are optional, meaning health and dependent care FSAs can take advantage of some or all of them – but are not required to do so. For those plans that want to, plan amendments will be needed.

The CAA provides that plans can begin operating in accordance with these provisions immediately, so long as the appropriate amendments are adopted 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 example, a calendar year plan that chooses to take advantage of an option for the 2020 plan year apparently would need to adopt the appropriate amendment(s) no later than December 31, 2021.

IRS guidance on specific questions relating to the timing of plan amendments and other aspects of these provisions is expected in the near future.

New Transparency Rules for Group Health Plans

A series of provisions in the CAA, 2021 will ban "gag clauses" in provider agreements, require brokers and consultants to disclose to the relevant plan fiduciary their direct and indirect compensation for services provided to the group health plan, and establish a new reporting requirement relating to a plan's prescription drug costs.

Ban on "Gag Clauses"

Agreements between health care providers, third-party administrators, and group health plans often preclude plans from sharing certain types of information regarding cost or quality of care with participants or others. These so-called "gag clauses" have been criticized by some as an impediment to plan

sponsors' abilities to negotiate better deals and to participants' abilities to make informed choices about providers.

In response, effective immediately (i.e., as of December 27, 2020) the CAA amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) to prohibit group health plans and health insurers issuing group health coverage from entering into an agreement with a provider, network of providers, or third-party administrator that would directly or indirectly restrict the plan or issuer from:

- Giving provider-specific cost or quality of care information to referring providers, the plan sponsor, enrollees, or those eligible to enroll in the plan or coverage;
- Electronically accessing de-identified claims and encounter data for each enrollee in the plan or coverage, including financial information, provider information, service codes, or other relevant data elements; or
- Sharing any such information with a business associate, as defined in HIPAA.

Note that the new rule does not prohibit providers or networks from placing "reasonable restrictions" on publicly disclosing any of the above information.

The group health plan or health insurance issuer must provide an annual attestation to the Secretary of Health & Human Services, Labor, or Treasury (as appropriate) of compliance with these rules.

Disclosure of Direct and Indirect Compensation for Brokers and Consultants

In general, ERISA § 406 prohibits ERISA plan fiduciaries from causing the plan to enter into certain transactions with parties in interest, including service providers such as brokers and consultants. However, ERISA § 408(b)(2) provides an exemption for "reasonable arrangements" with a party-in-interest for "legal, accounting, or other services necessary for the establishment or operation of the plan, if no more than reasonable compensation is paid therefor."

The Department of Labor previously has issued regulations (Labor Reg. § 2550.408b-2) to impose more specific reasonableness requirements for retirement plan fiduciaries entering into service provider contracts, including disclosure of direct and indirect compensation. The regulation's disclosure requirements currently do not apply to welfare plans – a gap the CAA is now filling by statute.

In particular, the CAA amends ERISA to provide that a contract between a group health plan (i.e., a "covered plan") and a "covered service provider" (generally one that expects direct and indirect compensation of $1,000 or more with respect to certain brokerage and consulting services) is not reasonable unless the covered service provider discloses to a responsible plan fiduciary, in writing and reasonably in advance of the date the contract or arrangement is entered into, extended or renewed, specific information about direct and indirect compensation, including information about the source of any indirect compensation.

This new rule will take effect on December 27, 2021.

Pharmacy Benefit and Drug Cost Reporting

The CAA also amends ERISA, the PHSA, and the IRC to require group health plans and health insurance issuers offering group insurance coverage to annually report to the Secretaries of Labor and Treasury specific information about the

plan's prescription drug and overall health care services spending for the previous year, as well as about the top 50 prescription drugs driving the plan's prescription drug spending.

The initial report is due no later than one year after December 27, 2021, and annually by June 1.

House Democrats Introduce Pension Funding Relief Bill

A bill that would provide funding relief to single-employer pension plans and special relief for multiemployer pension plans has been introduced in the early days of the new Congress and could be included in the next round of COVID-related stimulus legislation.

Committee action is expected in this bill because the "Emergency Pension Plan Relief Act of 2021" is sponsored by the chairs of the two key committees of jurisdiction, Chairman Bobby Scott of the House Committee on Education and Labor and Chairman Richard Neal of the House Committee on Ways and Means. Whether and when the full House would take up a version of the bill is an open question. However, the bigger question is whether Senate Democrats will attempt to include a version of these proposals in a budget reconciliation bill that is likely to be the legislative vehicle of choice for tax and budget-related provisions that might otherwise be subject to a filibuster.

Single-Employer Plan Funding Relief

For single-employer plans the bill would more than double the funding shortfall amortization period, from 7 years to 15 years. Under the proposal, any shortfall amortization bases for plan years preceding the proposal's effective date would be reset to zero so that all funding shortfalls would be subject to the new 15-year amortization period.

Additionally, the bill would extend the period for widening the pension funding stabilization corridor. Briefly, the 3 segment rates used to determine a plan's funding target and target normal cost may only fluctuate within a corridor based on the 25-year average for each rate. The current corridor is 85% to 115%, which will incrementally widen to 70% to 130% beginning in 2024.

The proposal would reset the corridor to 95% to 105% from 2020 through 2025, and then resume incrementally widening each year until it reaches 70% to 130% for 2030 and beyond. Additionally, the bill would provide that the 25-year average for any segment rate may not be less than 5%.

Modifications to Multiemployer Plan Rules

For multiemployer plans, the bill would expand PBGC's authority to partition troubled plans. It also would repeal the Multiemployer Pension Reform Act of 2014's benefit suspension provisions. The bill also would permit any multiemployer plan in endangered or critical status for a plan year beginning in 2020 or 2021 to extend its rehabilitation period by 5 years. Additionally, it would

almost double to PBGC's maximum benefit guarantee for multiemployer plan participants.

What Does This Mean?

For now, plan sponsors must continue following current funding rules without regard to these proposed changes. The rules will change only if and when these (or similar) proposals are approved by both the House and Senate and signed into law by President Biden. Watch Rewards Policy Insider for additional updates.

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