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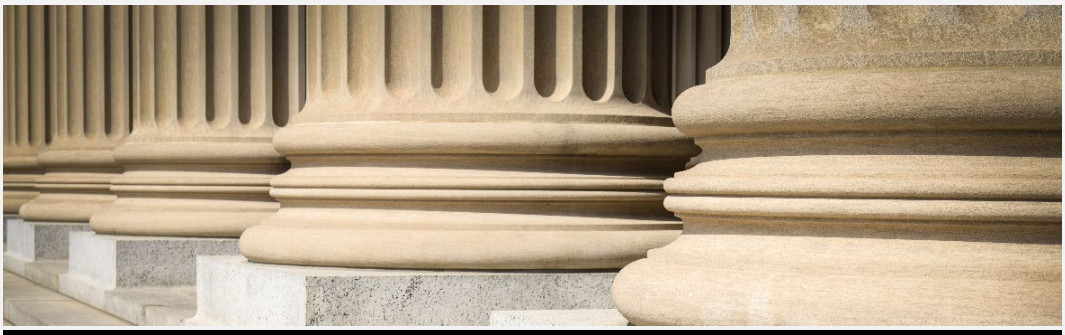
United States | Human Capital | 26 February 2021



Rewards Policy Insider
2021-3

In this Issue:

"Surprise Billing" Reform and Other Group Health Plan Provisions in CAA, 2021

One of the big headlines emerging from the Consolidated Appropriations Act (CAA), 2021, was the bill's provisions addressing "surprise billing" by emergency providers and facilities, and by air ambulance service providers. However, the bill also includes a number of significant new requirements for group health plans and issuers of group health coverage that are in addition to the transparency and mental health parity provisions discussed in Rewards Policy Insider (RPI) 2021-1 and -2, respectively. Unless otherwise noted, the following new requirements are all effective for plan years beginning on or after January 1, 2022.

Other Group Health Plan Provisions

Many of the new provisions can be grouped into the broader theme of transparency – with respect to how much the plan is responsible for paying, the participant's cost-sharing obligations, and which providers are and are not part of the plan's provider network – that was a focal point for the previous Administration.

Notably, group health plans and issuers of group coverage will be required to:

- Include deductibles and out-of-pocket maximums, as well as information about where to go to find out about providers and facilities in the plan's network, on any physical or electronic insurance identification cards;
- Provide "clear and understandable" advance cost estimates for items or services an enrollee has scheduled with a provider or facility, including a good faith estimate of the plan's responsibility and the participant's cost-sharing obligations;
- Make available on their websites a price comparison tool that enrollees can use to compare their cost-sharing obligations for specific items or services obtained from in-network providers; and
- Make available on their websites a database identifying all in-network providers, which must be verified and updated every 90 days.

There are also new rules requiring group health plans and issuers to allow "continuing care patients" to elect to continue a course of treatment under the same terms and conditions with a specific in-network provider or facility for up to 90 days after the provider or facility's in-network status is changed or terminated.

A "continuing care patient" with respect to a provider or facility is someone who is:

- Undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo nonelective surgery from the provider, including the receipt of postoperative care from the provider or facility; or

- Is terminally ill and is receiving treatment for such illness from the provider or facility.

Upon terminating a contract with a provider or facility or other changes to the provider or facility's status with respect to the plan, the plan must:

- Timely notify all enrollees who are continuing care patients with respect to the provider or facility of their continuity of care rights, and permit them to inform the plan of their need to elect continued transitional care from the provider or facility; and
- Allow the patient to elect to continue to have benefits as if the provider or facility were still in-network for 90 days, but only with respect to the course of treatment relating to the individual's status as a continuing care patient.

Surprise Billing

As noted, the bill includes a series of new rules designed to help participants avoid "surprise billing" by out-of-network providers that provide them care in emergency rooms and in the context of air ambulance services. These changes, which will affect group health plans and issuers of group coverage as well as health care providers and facilities, will be summarized in an upcoming edition of Rewards Policy Insider.

Observations

These and other CAA provisions are part of the significant list of new compliance obligations for group health plans beginning in 2022. Some of the new requirements – such as putting cost-sharing information on identification cards and building an in-network provider database – may not be too far removed from a plan's current practice. Others, like the ones relating to advance cost estimates and continuity of care, may require the development of more significant new compliance infrastructure.

Then, there is the online price comparison tool requirement, which appears to largely overlap with parts of the Transparency in Coverage final rule that regulators issued late last year. This is significant because the relevant part of the Transparency in Coverage final rule is phased in over two years, starting in 2023. As noted above, this new statutory requirement is effective for plan years beginning on or after January 1, 2022.

Clarifying guidance on this and other relevant CAA requirements is expected in the future, although timing is uncertain.

DEVELOPING: New Stimulus Bill Includes Employee Benefits-Related Provisions

President Biden's stimulus package is now making its way through Congress, and the issues in play include single-employer pension funding relief, temporary COBRA subsidies for certain COBRA beneficiaries, and temporary

incentives for employers to provide paid family and medical leave benefits to employees. Other provisions include a temporary increase to the exclusion for employer-provided dependent care assistance and changes to the ACA's premium tax credit for 2021 and 2022.

The House Budget Committee approved the American Rescue Plan on February 22, and the House is expected to vote on – and pass – the bill as early as February 26. From there the focus will shift to the Senate, which is in the process of developing its own reconciliation bill.

Due to Senate rules, some provisions in the House bill – such as the proposed increase in the federal minimum wage to $15 per hour – may not be included in the Senate version. There may be other changes as well.

Typically a joint House-Senate conference would be convened to resolve differences between the House and Senate bills. The House almost certainly will accede to the Senate bill in this case, both because of the peculiarities of Senate rules and because all 50 Senate Democrats likely will need to be on board with the bill for it to pass.

Final action is expected by mid-March, when enhanced federal unemployment benefits are currently scheduled to expire.

Pension 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 beginning after December 31, 2019 (or after December 31, 2018, at the plan sponsor's election) 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%.

The bill also includes significant modifications to the multiemployer plan rules.

ACA Premium Tax Credit

The bill would make several changes to the eligibility criteria for Premium Tax Credits under the Affordable Care Act (ACA). Significantly for employers, for 2021 and 2022 the bill would eliminate the 400% of the federal poverty level cap on premium tax credit eligibility. If this change is enacted, employers that increase premium contribution requirements for higher income employees may need to review their plans to ensure this change does not potentially expose them to shared responsibility penalties for workers earning above 400% of the federal poverty level.

COBRA Subsidies

For the period beginning on the first day of the month following the date of enactment, and ending on September 30, 2021, "assistance eligible individuals" would be responsible for no more than 15% of their COBRA premiums. An "assistance eligible individual" would be defined as anyone who elects COBRA coverage as the result of any qualifying event other than the voluntary separation of employment. An advanceable credit against the plan sponsor's or insurer's Hospital Insurance (HI) payroll tax liability would be available to subsidize the other 85% of the premium cost.

For those who would be assistance eligible individuals but for their failure to elect COBRA coverage, employers would have to offer a special COBRA election period.

Paid Family and Medical Leave

The bill would extend availability of the Families First Coronavirus Relief Act's (FFCRA) paid sick and family leave tax credits from March 31, 2021 through September 30, 2021. It would also increase the wages for which an employer can claim the credit from $10,000 to $12,000 per employee. However, as with the CAA, the FFCRA's paid sick and family leave mandates would not be extended.

Additional changes would include nondiscrimination requirements to prevent employers from claiming the credit if they make leave available in a way that discriminates in favor of highly compensated employees, full time employees, or based on employee tenure.

The tax credits would also be made available to state and local government employers.

Employer Provided Dependent Care Exclusion

For 2021 only, the bill would increase the exclusion for employer-provided dependent care assistance from $5,000 to $10,500. Presumably, the increased limit would also apply to dependent care flexible spending arrangements (FSAs).

Certain Plan Periods and Timeframes, Suspended for the Last Year, Might Start Running Again in March

Last year the Departments of Labor and Treasury issued guidance to automatically extend certain employee benefit plan-related deadlines and other timeframes during the COVID-19 National Emergency. With the statutory authority for those extensions ending on February 28, it is not completely clear what will happen next.

Briefly, the guidance provided that the period from March 1, 2020 through 60 days after the end of the Presidentially declared COVID-19 National Emergency (i.e., the "outbreak period") must be disregarded for purposes of determining certain periods and dates, including –

- The 30-day (or 60-day, if applicable) period for an employee to exercise his or her HIPAA special enrollment rights;
- The 60-day COBRA election period, as well as any deadlines for paying COBRA premiums;
- The deadline for filing claims for benefits, appealing adverse benefit determinations, and exercising other rights under the plan's claims procedure rules.

The underlying statutory authority for these automatic extensions is ERISA Section 518 and IRC Section 7508A(b), which limits their duration to no more than one year. That means all the time limits this guidance has suspended since last March could start to run again as early as March 1.

For clarity, additional guidance from the Departments of Labor and Treasury is needed. In the meantime, sponsors of plans subject to ERISA and the Internal Revenue Code should be aware that they may be permitted to begin running the relevant time periods that have been suspended on March 1, and consider making a plan for communicating that information to affected participants and beneficiaries.