2021 RESILIENT TOGETHER

# PEELING BACK THE LAYERS OF THE CONSOLIDATED APPROPRIATIONS ACT (CAA)

BKS PARTNERS
A BALDWIN RISK PARTNER

INSGROUP
A BALDWIN RISK PARTNER

AHT INSURANCE
A BALDWIN RISK PARTNER

Burnham
A BALDWIN RISK PARTNER

# WEBINAR LEGAL DISCLAIMER

You are attending a webinar ("Webinar") presented by Baldwin Risk Partners, LLC, on behalf of itself, its affiliates and/or its invited guest presenters, if any ("BRP"). The Webinar is made publicly available and is offered free of charge.

Your participation and/or attendance in this Webinar, or the receipt of any information from BRP in connection with this Webinar, is not intended to create nor does it create a broker/risk manager, legal, medical or other relationship between you and BRP. The content, including links to other sites and publications, included in this Webinar is not intended to constitute comprehensive insurance, risk management, legal or medical advice. You should seek individual advice or other professional advice before acting or relying on the content or information in this Webinar.

The information and materials provided in connection with this Webinar is provided "AS IS" with all faults. BRP does not warrant the accuracy, adequacy or completeness of the information and materials provided in connection with this Webinar and expressly disclaims liability for errors or omissions in this information and materials. Except as may be required under applicable law, no warranty of any kind implied or express, including but not limited to the warranties of non-infringement of third-party rights, title in, merchantability of or fitness for a particular purpose is given.

# PANELISTS

## PEELING BACK THE LAYERS OF THE CONSOLIDATED APPROPRIATIONS ACT (CAA)

LORELAI MENTZER
MODERATOR
AHT INSURANCE

LISETTE SELL
COUNSEL
DAVIS WRIGHT TREMAINE

KEN JEWELL - Contributor
PARTNER
BKS PARTNERS

JIM MAULFAIR
PARTNER
AHT INSURANCE

RICHARD ASENSIO
VICE PRESIDENT &
DIRECTOR OF COMPLIANCE
BURNHAM BENEFITS

BILL FREEMAN
ASSOCIATE DIRECTOR
AHT INSURANCE

STEPHANIE HALL
ASSOCIATE DIRECTOR,
BENEFIT COMPLIANCE
RBA BENEFITS

PAUL VAN BRUNT
SENIOR COMPLIANCE
CONSULTANT
BKS PARTNERS

# HEALTHCARE PROVISIONS

# Health Care and Dependent Care FSA Administration
## General Rules

- Health Care FSA and Dependent Care FSA elections are **irrevocable for the plan year** (typically the calendar year)
- Unused amounts in a Health Care FSA or Dependent Care FSA accounts are forfeited at the end of the plan year, **subject to 3 exceptions**:

1. **RUN-OUT RULE:** Expenses incurred during plan year may typically be reimbursed up to **90 days** after close of plan year

2. **CARRY-OVER RULE:** A Health Care FSA account (but not a Dependent Care FSA) may permit **up to $550** to be carried over to the next plan year

3. **GRACE PERIOD RULE:** Expenses incurred during the first **2.5 months** of the following plan year may be utilized against the prior year's FSA account balances.
    1. Plan can use either the Carry-Over Rule or the Grace Period Rule but not both
    2. Plan can use the Run-Out Rule in addition to either the Carry-Over Rule or the Grace Period Rule

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

- **Extended Carry-Over Rule** and **Extended Carry-Over Balance**
  - Entire unused balance in either a Health Care FSA or a Dependent Care FSA at the end of 2020 plan year can be carried forward into 2021 plan year; entire unused balance in either FSA at the end of 2021 plan year can be carried forward into 2022 plan year
  - Health Care FSA carry-over amounts can only be used for qualified Health Care expenses and Dependent Care FSA carry-over amounts can only be used for qualified Dependent Care FSA expenses
    - **Balances may not be transferred from Health Care FSA to Dependent Care FSA, and vice versa**

**Implementation Considerations:**

- Could prevent employee from making contributions to a health savings account
- Cannot have both carry-over provision and grace period simultaneously
- Subject to Section 125 and 129 nondiscrimination rules, employer may adopt relief for some, but not all, FSA participants

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

- **Grace Period Extension**
  - 2.5-month grace period following end of plan year is extended to 12 months following the end of plan year
    - Applies to both Health Care FSAs and Dependent Care FSAs
    - For example, grace period ending in 2021 (March 15, 2021 for calendar year plans) can be extended to December 31, 2021; grace period ending in 2022 can be extended to December 31, 2022
  - Health Care FSA extension period can only be used for qualified Health Care expenses and Dependent Care FSA extension period can only be used for qualified Dependent Care FSA expenses
    - Balances may not be transferred from Health Care FSA to Dependent Care FSA, and vice versa

**Implementation Considerations:**

- Could prevent employee from making contributions to a health savings account
- Cannot have both carry-over provision and grace period simultaneously
- Subject to Section 125 and 129 nondiscrimination rules, employer may adopt relief for some, but not all, FSA participants
- Terminated participants could have access to grace period extension

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

- **Elections are not irrevocable for 2021**
  - Prospective changes for any reason (i.e., no qualifying event required) are permitted to Health Care FSA and Dependent Care FSA elections in 2021

☑ **If revoke election, options are:**

- Make available for reimbursement of expenses incurred for the rest of plan year
- Make available to reimburse expenses incurred prior to revocation only, or
- Require balances to be forfeited; no cash payout permitted

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

### Implementation Considerations Related to Making Election Changes:

- Could establish specific timeframe for participants to make mid-year changes
- Employer could also limit the number of election changes allowed
- Potential additional administration costs
- Address impact on HSA eligibility
  - Permit change from General Purpose FSA to Limited Purpose FSA and vice versa
  - Permit employee to forfeit balance in FSA
  - Permit employee to opt out of carryover or grace period extension
- While contribution election changes are prospective, employer may still permit the amended contribution amounts to be used for expenses incurred anytime during the first plan year beginning on or after January 1, 2021 through the end of the 2021 plan year

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

- Extension of Claim Deadlines for Terminated Participants
  - **Terminated participants**, including those who stop contributing in 2020 or 2021, **can access their Health Care FSA accounts through the end of the plan year** in which their participation terminates, plus any grace period
    - For example, a participant who terminated in 2020 could access their account through December 31, 2021 without the need to elect COBRA
    - Could adopt similar rules for Dependent Care FSA could utilizing existing regulations

  - Unused amounts in Health Care FSA can be limited to contributions made up to time participation ceased

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

- **Age to Access Dependent Care FSA Reimbursements Extended**
  - **Employment-related expenses for childcare services are reimbursable if the care provided is for a child under the age of 13**
    - If the age of 13 is reached during a year in which the regular enrollment was on or before January 31, 2020 (typically the 2020 calendar year), the plan can substitute age 14 for age 13 and utilize any unused account balance that is being carries forward into 2021

# Health Care and Dependent Care FSA Administration

## Optional Special Rules

### ACTION STEPS

1. **Determine** whether to allow optional change

2. **Retroactive** plan amendments permitted

3. **Amend** by last day of calendar year following close of plan year for which change is effective
   - For 2020 changes to a calendar year plan, amendment must be adopted by December 31, 2021; for 2021 changes to a calendar year plan, amendment must be adopted by December 31, 2022

4. **Plan must have been operated consistently with the amendment terms until it is adopted**

# Ban on Surprise Medical Bills

- Protects patients treated at out-of-network (OON) facility or who are unknowingly treated by an OON provider at an in-network (IN) facility from billing by the OON provider or facility in excess of what group health plan will pay
- Applies to fully-insured and self-insured group health plans
- Applies to health insurance carriers in both individual and group markets
- Effective for plan years beginning on or after January 1, 2022
  - HHS regulations to be proposed by July 1, 2021

# Ban on Surprise Medical Bills

- **Emergency Services** provided by OON provider/at OON facility (hospital's ER department or freestanding ER department), including items/services provided after stabilization and provided during stay connected to emergency services

  - Must cover without prior authorization/condition
  - Must only charge IN cost-sharing
  - Cost-sharing applied to IN deductible and out-of-pocket maximum
  - Must be no balance billing

# Ban on Surprise Medical Bills

- **Non-emergency Services** provided by OON provider at IN facility
  - Must only charge IN cost-sharing
  - Cost-sharing applied to IN deductible and out-of-pocket maximum
  - May balance bill if patient knowingly and voluntarily consents after receiving written notice from provider at least 72 hours prior to when services are scheduled which includes notice that provider/facility is OON, statement that consent is optional, good faith cost estimate, and identification of available IN options
    - Not allowed if provider of ancillary services (e.g., anesthesiologist)
    - Not allowed for any item or service that is furnished as a result of unforeseen, urgent medical needs that arise at the time a covered item or service is furnished

# Ban on Surprise Medical Bills

- **OON Air** (not Ground) **Ambulance Services**
  - Must only charge IN cost-sharing
  - Cost-sharing applied to IN deductible and out-of-pocket maximum
  - Must be no balance billing

- **Ground Ambulance Services**
  - Labor, Treasury and HHS to establish advisory committee on patient billing for ground ambulance services which will submit report to Congress within 180 days of first committee meeting

# Ban on Surprise Medical Bills

- **IN cost-sharing based on "recognized amount"**
  - Amount determined by applicable state law or regulation (for an insured plan),
  - If no applicable law (for self-funded plan), the "qualifying payment amount," or
    - Based on median contracted rate recognized by plan
  - Amount state approves if state has an all-payer model agreement in effect with CMS

# Ban on Surprise Medical Bills

- **Payments to OON Providers**
  - Within 30 days, plan must either deny the claim or, determined to be covered, send an "initial payment" directly to provider
    - Initial payment is amount allowed under plan less cost-sharing (e.g., copayment, coinsurance, etc.
  - Parties have 30 days (after denial or initial payment) to initiate negotiations to determine amount to be paid
  - If parties can't reach agreement after 30 days of negotiation, either party has 4 days to notify the other and HHS of intent to initiate the binding Independent Dispute Resolution process
    - Each party submits a payment proposal and the arbitrator chooses one of the proposals
    - Chosen amount must be paid by plan in 30 days
    - Losing party must pay entire cost of arbitration
    - Parties split cost if they agree on amount before arbitrator chooses

# Ban on Surprise Medical Bills

## ACTION STEPS

1. **Update** health plan document and SPD as necessary
2. **Discuss** IDR process with TPA and revise service agreement, if needed

# Mental Health Parity

- **Mental Health Parity and Addiction Equity Act of 1996 prohibits a group health plan that provides mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical (Med/Surg) benefits provided under the plan**
  - One type of such limitation is a **nonquantitative treatment limitation (NQTL)**
    - Non-numerical limitation on benefits such as preauthorization requirement or written treatment plan requirement
  - NQTL cannot be imposed with respect to MH/SUD benefits unless, under the terms of the written plan/coverage and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are not applied more stringently than, the processes used in applying the limitation with respect to Med/Surg benefits
    - NQTL doesn't have to be identical for MH/SUD benefits and Med/Surg benefits

# Mental Health Parity

- **As of February 10, 2021, group health plans and health insurance carriers are required to perform and document a formal analysis of the design and application of any NQTL applicable to MH/SUD benefits**
  - Identification of NQTL and benefits to which it applies
  - Factors considered in the design of the NQTL
  - Evidentiary standards and sources used to develop the factors
  - Comparative analysis demonstrating that the NQTL as applied to MH/SUD benefits, both as written and in operation, is comparable to, and is not applied more stringently than the NQTL as applied to Med/Surg benefits
  - Findings and conclusions establishing compliance

- **Formal NQTL analysis must be made available**, if requested, to the appropriate state authority or the secretaries of HHS or DOL
  - CAA provides that the secretaries are to request analyses from at least 20 group health plans each year

- If it is determined, after reviewing the analysis, that the NQTL does not comply with parity requirements, the plan must identify corrective action to be taken and submit a new analysis documenting compliance within 45 days
  - If the agency finds that the plan is still not in compliance, it will so notify all plan participants within 7 days

# Mental Health Parity

## ACTION STEPS

1. **Determine** whether group health plan is subject to NQTL analysis requirement

2. If so, **confirm** that your mental health parity vendor/TPA can perform the NQTL analysis and have analysis undertaken asap
   - If insured plan, carrier will perform NQTL analysis so request confirmation of compliance from carrier

3. **Redesign** and amend plan (and update SPD) if NQTL analysis reveals noncompliance with parity requirements

4. **Prepare** to respond to requests for NQTL analysis

# Extended Employer Assistance for Student Loans

- **Under the CARES Act, an employer may make one or more nontaxable payments on a qualified education loan incurred by an employee for his or her education, subject to an annual cap of $5,250,**
  - Payments can be made directly to the lender or to the employee
  - $5,250 cap applies to all education assistance (such as tuition, fees, and books) that the employer is already providing to the employee in addition to the student loan payments
  - "Qualified education loan" means indebtedness incurred by the employee solely to pay qualified higher education expenses which (i) are incurred on behalf of the employee as of the time the indebtedness was incurred, (ii) are paid or incurred within a reasonable period of time before or after the indebtedness is incurred, and (iii) are attributable to education furnished while the employee was an eligible student
  - Also includes indebtedness used to refinance qualified education loan indebtedness.
  - "Qualified higher education expenses" are the costs of attending an eligible educational institution (i.e., a public, nonprofit or privately owned for-profit school offering higher education beyond high school, including any institution with an internship or residency program leading to a degree or certificate awarded by an institution of higher education, a hospital or a health care facility which offers post-graduate training)
  - "Eligible student" is one who meets the requirements of Section 484(a)(1) of the Higher Education Act of 1965 and is carrying at least half the normal full-time workload for the course of study the student is pursuing

- **Under CARES Act, payments had to be made after March 27, 2020 and prior to January 1, 2021**
  - **CAA extends sunset date to January 1, 2026**

# RETIREMENT PLAN PROVISIONS

# Recent Retirement Plan Legislation

**SECURE Act – Signed Dec. 20th, 2019**

- 1st piece of retirement plan legislation in more than a decade

**CARES Act – Signed Mar. 27th, 2020**

- Pandemic relief provisions impacting retirement plans

**Consolidated Appropriations Act, 2021 – Signed Dec. 27th, 2020**

# Consolidated Appropriations Act, 2021

**Retirement Plan Provisions**

- DOL e-Delivery Report Requirement
- Employer Defined Benefit Plan Transfers for Future Retiree Med/Life Insurance Costs
- Age 55 Distributions for Certain Employees in the Building and Construction Industry
- Partial Plan Termination Temporary Relief
- Disaster-Related Distributions
- Money Purchase Plan Coronavirus-Related Distributions

**CAA did <u>not</u> extend any CARES Act deadlines for:**

- ☒ Coronavirus-related distributions
- ☒ Loan Repayments
- ☒ Waivers of Required Minimum Distributions (RMD)

# COMPLIANCE PANEL

BKS PARTNERS
A BALDWIN RISK PARTNER

INSGROUP
A BALDWIN RISK PARTNER

AHT INSURANCE
A BALDWIN RISK PARTNER

Burnham
A BALDWIN RISK PARTNER

# WeAreResilientTogether.com

# THANK YOU

BKS PARTNERS
A BALDWIN RISK PARTNER

INSGROUP
A BALDWIN RISK PARTNER

AHT INSURANCE
A BALDWIN RISK PARTNER

Burnham
A BALDWIN RISK PARTNER