Consolidated Appropriations Act, 2021 Group Health Plan Considerations and COVID-19 Vaccine Wellness Programs

Presented by:

Lorie Maring
Phone: (404) 240-4225
Email: lmaring@fisherphillips.com

Agenda

- Overview of the No Surprises Act
- CAA and IRS COVID Relief for health FSAs and DCAPs and plan amendment considerations
- CAA Required NQTLs on mental health and substance use disorder benefits requirement
- Vaccine Incentive Wellness Program Considerations under ERISA, HIPAA, ADA and GINA

No Surprises Act

Effective for plan years beginning on or after January 1, 2022

Preventing Surprise Medical Bills

- Emergency Services at Hospital
- Air Ambulance
- Non-Emergency Services by OON Providers at In-Network Facilities

Preventing Surprise Medical Bills

- For emergency services at OON hospital ER or OON freestanding ER:
  - No prior authorization and at in-network rates
  - May impose provisions excluding services, waiting periods and COB
  - Applies to facility and professional services
  - Includes post-stabilization period until person moved to another facility

Preventing Surprise Medical Bills

- Non-Emergency Services by OON Provider at an In-Network Facility
  - OON Provider may not bill patient more than the "recognized amount" unless satisfy "notice and consent" procedure
- OON Provider may balance bill if provide cost estimate and obtain individual's consent at least 72 hours prior to treatment – *certain providers excluded. including anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons and labs*

Ending Surprise Air Ambulance Bills

OON Air Ambulance Providers prohibited from billing patient for more than “recognized amount”

Determination of Out-of-Network Rates "Recognized Amount"

Plans must calculate the cost-sharing requirement as if the total amount that would have been charged was equal to the statutorily defined "Recognized Amount," set as:

- the amount approved by the state in the case of items and services furnished in a state with an All-Payer Model Agreement; or
- the market-based median in-network rate, called the "Qualifying Payment Amount," or
- the amount determined in accordance with state law (to the extent the state has an applicable law)

Plans also must count cost-sharing payments for such out-of-network emergency or non-emergency services toward any applicable in-network deductible or out-of-pocket maximum

Negotiation and Independent Resolution Process

Payment Negotiation and IDR Procedures – ACA "greater of three" payment for emergency OON is now superseded. New method as follows:

- Health plan has 30 days from initial bill to make "initial payment" or deny payment
- When OON provider receives notice of payment or denial – 30-day period to negotiate agreed upon amount
- If no agreement within 30 days, IDR Process may be initiated
  - Notice to HHS and other party within 4 days
  - No minimum threshold of payment amount to initiate IDR

Notice and Disclosure Requirements Health Plans

- Disclosure of balance billing protections
- Updated Insurance Cards with cost sharing and contact info for questions
- Advance Explanation of Benefits for scheduled services, including provider's network status and good faith estimate of charges
- Notification of network status changes for continuing care patients
- Online price comparison tool for participating providers
- Updated provider directories (at least every 90 days) and respond to requests for information

Notice and Disclosure Requirements Health Care Facilities and Providers

- Disclosures of Patient Protections Against Balance Billing
  - Publicly available on website
- Notice of Good Faith Estimates of Scheduled Services
  - HHS must establish by 1/1/2022 a dispute procedure between patients and providers in addition to IDR for plans/payers and providers
- Notice of Facility and Provider Network Status
  - If an incorrect network status is provided to patient and patient pays an amount in excess of the in-network cost-sharing amount, the provider must refund the excess amount, plus interest

Regulatory Guidance Forthcoming

- HHS must issue regulations by 10/1/2021 regarding audits to ensure compliance
- HHS must issue regulations by 7/1/2021 regarding determination of qualifying payment amount
- Under the Act, HHS, the Department of Labor (DOL), and the IRS are to issue regulations to govern IDR process within one year of enactment of the law

Temporary Health FSA and DCAP Relief

The Consolidated Appropriations Act, 2021

- Mid-Year FSA Election Change Relief
- Unlimited Carryover Relief
- Extended Grace Period Relief
- Health FSA Spend Down Relief
- DCAP Age Limit Relief

IRS Notice 2021-15 – New Relief

Clarifies 125 plans may retroactively adopt CARES Act amendment to allow reimbursement of OTC and Menstrual Care Products

- Any period on or after January 1, 2020 without disqualifying the plan

IRS Notice 2021-15 – New Relief

- Mid-Year 125 Election Change Relief – PYE in 2021
  - New election for health coverage
  - Revoke existing election for health coverage and enroll in other coverage of same employer
  - Revoke existing election for health coverage if attest to other health coverage not sponsored by employer – model attestation provided
- No change in status required!

Midyear Election Changes to FSAs

- May change existing health FSA and DCAP elections during 2021 plan year without a change in status
  - revoke an election, make one or more elections, increase or decrease an existing election
  - Initial enrollment mid-year also permitted
  - No refund of previously contributed amounts (no retroactive changes)

Midyear Election Changes to FSAs

- Relief is optional and employers may impose conditions, e.g.
  - Limited window for elections
  - Limit changes to amounts not less than current reimbursements
- Employers who allow employees to revoke elections may provide either
  - continued claims reimbursement after mid-year change of amounts already contributed (through PY ending in 2021)
  - Amounts contributed before revocation only available for expenses incurred prior to revocation (e.g. to preserve HSA eligibility)

Unlimited Carryover Relief

- May allow FSA and DCAP participants to carryover any unused contributions remaining from the 2020 plan year to the plan year ending in 2021 (may include 2019 unused contributions if employer adopted prior relief extending grace or claims period deadlines in 2020).
- Additionally, FSAs and DCAPs may permit participants to carryover any unused contributions remaining in the FSA or DCAP from the 2021 plan year to the plan year ending in 2022.
- Carryovers into 2021 or 2022 not limited to the $550 maximum
- May not have both carryover and grace period
- Amounts carried over will not impact COBRA premiums, non-discrimination testing or maximum contribution limit in subsequent year

Unlimited Carryover Relief

- Carryover relief is optional and employers may
  - Impose a cap on amount carried over
  - Impose a deadline to use carried over amounts within subsequent plan year
  - Allow employees to opt out of carryover to utilize HSA
- May not have both carryover and grace period, but may adopt carryover under IRS relief if have a grace period, carryover or neither

Extended Grace Period Relief

- Appropriations Act permits FSAs and DCAPs to extend the grace period for plan years ending in 2020 or 2021 for 12 months instead of 2-1/2 months following end of the plan year.
- Participants may opt out of extended grace period to have HSA coverage
- Amounts made available in extended grace period will not be taking into account for nondiscrimination testing or COBRA premiums
- May not have both carryover and grace period, but may adopt extended grace period under IRS relief if have a carryover, grace period or neither

Health FSA Spend Down Relief

- May allow employees who cease participating in a health FSA or DCAP during calendar year 2020 or 2021 to continue to spend down unused account balances through the end of the plan year - including any grace period.
- *Not available if employer adopts carryover relief – cannot have both spend down relief and carryover relief for same participants*
- *COBRA still applies to extent employee is underspent even if amend plan to adopt relief*

DCAP Carry Forward

- Current DCAP rules limit reimbursement of qualifying dependent care expenses to children under age 13.
- Appropriations Act allows extension of maximum age for dependents from 12 to 13 for eligible dependents who turned 13 (i.e., aged out of eligibility) during the last plan year with an open enrollment period ending on or before January 31, 2020.
- Employers can allow unused dependent care FSA amounts for children until they turn age 14, at least through the end of the 2021 plan year.

Amendment Deadline

- Must amend their 125 (FSA) plan no later than the last day of the first calendar year beginning after the end of the plan year in which the change took effect.
- If the change takes effect January 1, 2021, the plan will need to be amended no later than December 31, 2022.
- The plan must be operated in accordance with the amendment retroactive to the effective date.

Mental Health and Substance Use Disorder Benefits Parity

Parity in Mental Health and Substance Use Disorder Benefits

- Appropriations Act requires group health plans or health insurance issuers offering group or individual health insurance coverage to formally document compliance with the MHPAEA requirements relating to NQTLs on mental health and SUD benefits.
- Only applies if plan imposes NQTLs on mental health and SUD benefits.
- Prepare to provide to state, DOL or HHS upon request by 2/10/2021 (45 days after enactment of Appropriations Act)

Parity in Mental Health and Substance Use Disorder Benefits

Comparative analysis must include:.

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or SUD and medical or surgical benefits to which each such term applies in each of the following six classifications: (i) inpatient in-network services, (ii) inpatient out-of-network services, (iii) outpatient in-network services, (iv) outpatient out-of-network services, (v) emergency care services, and (vi) prescription drugs.
2. The factors used to determine that the NQTLs will apply to mental health or SUD benefits and medical or surgical benefits.
3. The evidentiary standards used for the six factors noted above and any other source or evidence relied upon to design and apply the NQTLs to mental health or SUD 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 SUD benefits, as written and in operation, are comparable and not more stringent than NQTLs applied to medical or surgical benefits in the benefits classifications.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the comparative analyses that indicate that the plan or coverage is or is not in compliance with the NQTL requirements.

Parity in Mental Health and Substance Use Disorder Benefits

DOL or HHS, as applicable, is required to request no less than 20 analysis per year to audit

- If determined not in compliance, the plan or issuer must disclose the action the plan or issuer will take to become compliant and supplement the analyses within 45 days establishing compliance.
- If fail to establish compliance within the 45-day period, DOL/HHS will notify all individuals enrolled in the plan or insurance coverage that it has been determined to be not in compliance.

Appropriations Act also requires a public report of non-compliant plans be submitted to Congress and applicable state regulators

Vaccine Incentives Considerations for Wellness Programs

Vaccine Incentives: Considerations for Wellness Programs

Vaccine Incentive Program – must evaluate status as

- A wellness program
- An ERISA group health plan

Vaccine Incentives: Considerations for Wellness Programs

- HIPAA Nondiscrimination Rules/Wellness Requirements
  - Participatory vs. Health Contingent
  - Incentive Limitations
  - Alternatives
- HIPAA Privacy

Vaccine Incentives: Considerations for Wellness Programs

- Application of ADA Analysis
  - Medical Exam or Disability-Related Inquiry
  - Reasonable Accommodation – Religious or Medical
- No ADA Regulations on Permissible Incentives
  - Proposed Regulations issued January 2021 have been withdrawn
    - Would have limited incentive for participatory program to de minimis award (i.e. the water bottle rule….)

Vaccine Incentives: Considerations for Wellness Programs

- GINA Considerations
  - No collection of genetic information when asking for “proof” of vaccine
- Tax Considerations
- Title VII – Religious Objections
- FLSA Considerations

Vaccine Incentives: Considerations for Wellness Programs

Types of Incentives and Associated Risks

- Educating Employees: *little to no risk*
- Providing Paid Time Off To All Employees: *low risk*
- De Minimis For Those Who Get the Vaccine: *low risk*
- Paid Time Off For Those Who Get The Vaccine: *medium risk*

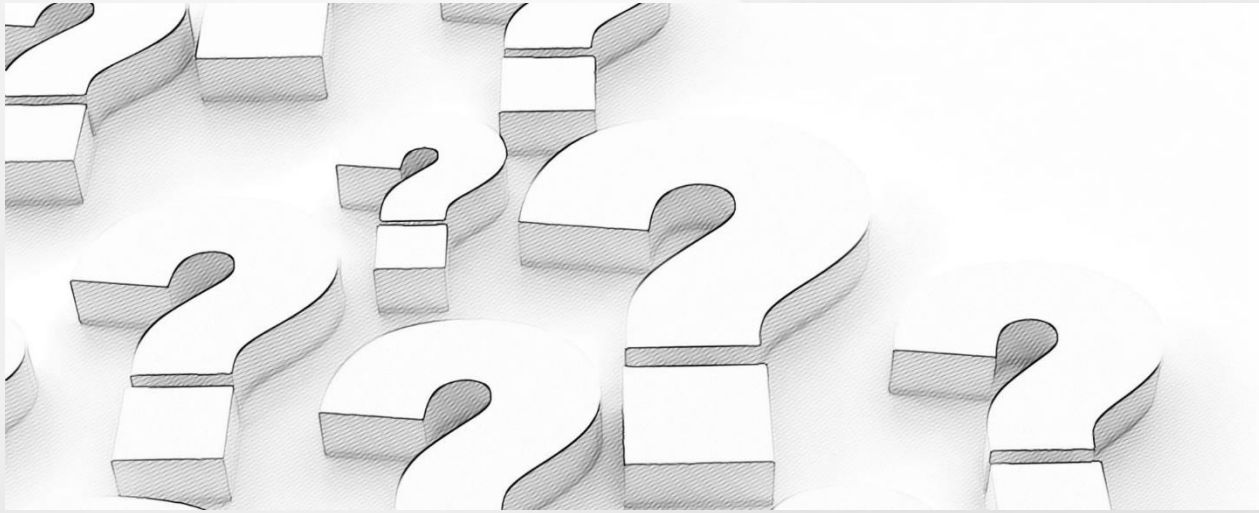
Vaccine Incentives: Considerations for Wellness Programs

Types of Incentives and Associated Risks….continued

- Providing Compensation To Cover "Costs" Associated With Vaccine: *medium risk*
- Making Vaccine Recipients Eligible For Prize Drawings: *medium risk*
- Offering An Incentive Of Greater Value For Those Who Get The Vaccine: *higher risk*

Final Questions

uba@fisherphillips.com



HRCI –

SHRM –

Presented by:

Lorie Maring
Phone: (404) 240-4225
Email: lmaring@fisherphillips.com

Thank You

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Phone: (404) 240-4225
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