Employee Benefits Provisions of the Consolidated Appropriations Act, 2021

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The Consolidated Appropriations Act, 2021 (the "Act") was signed into law by the president on December 27, 2020. The Act, comprised of several pieces of legislation, contains a number of employee benefits-related provisions, including:

- Temporary rules for flexible spending accounts, providing additional flexibility for participants to access funds in light of the COVID-19 pandemic.
- Temporary rules for assessing when a partial termination of a retirement plan occurs.
- Temporary rules regarding retirement plan distributions and loans concerning qualifying disasters (unrelated to the COVID-19 pandemic), including a waiver of the 10% penalty for early withdrawals, re-contribution of certain hardship withdrawals, an increase in plan loan limits, and the extension of plan loan terms.
- Temporary income exclusion of employer contributions up to $5,250 toward the repayment of an employee's student loan for higher education.
- Protection of group health plan participants from "surprise billing" of medical care when the participant has little or no control over who provides the medical care.

Each of these provisions is summarized in greater detail below.

Temporary Rules for Flexible Spending Accounts

(Sec. 214 of the Taxpayer Certainty and Disaster Tax Relief Act of 2020)

The Act contains temporary rules enabling participants to have greater access to health and dependent care flexible spending accounts ("FSAs"), generally applicable to the plan years ending in 2020 or 2021.

Carryovers. Health FSAs, but not dependent care FSAs, may permit participants to carry over up to $550 (as indexed for 2020) of unused amounts at the end of a plan year, to be used for qualified expenses incurred in a subsequent plan year. Under the Act, both a health FSA and a dependent care FSA may permit participants to carry over unused balances as of the end of the plan year ending in 2020 to the plan year ending in 2021, and to carry over unused balances as of the end of the plan year ending in 2021 to the plan year ending in 2022. For calendar year plans,

this means that unused balances as of December 31, 2020 and 2021 may be carried over, respectively, to 2021 and 2022.

Grace Period. A health FSA (that does not offer a carryover) and a dependent care FSA may provide participants the ability to access unused balances after the end of a plan year for the reimbursement of qualified expenses incurred during a grace period of up to 2.5 months after the end of the plan year. Under prior pandemic-related relief provided by the IRS in Notice 2020-29, for unused amounts remaining in a plan as of the end of a plan year or grace period ending in 2020, plans were permitted to extend the grace period until December 31, 2020. Under the Act, a health FSA and a dependent care FSA may extend the grace period for the plan year ending in 2020 or 2021 to 12 months after the end of the applicable plan year. For calendar year plans, this means that a grace period for the plan year ending as of December 31, 2020 or 2021 may be extended, respectively, to December 31, 2021 or 2022.

Post-Termination Reimbursement. A participant's coverage under a health FSA generally terminates on the participant's employment termination date or on the last day of the month in which the participant's termination of employment occurs (subject to the participant's right to elect COBRA coverage, in which case the employee would need to keep making contributions to continue coverage and be reimbursed for eligible post-termination expenses). A dependent care FSA, on the other hand, may permit employees who terminate employment to be reimbursed from their remaining balances for eligible post-termination expenses incurred during the remainder of the plan year (including any grace period for that year). The Act enables a health FSA to provide a participant who ceases participation in the plan during the calendar years 2020 or 2021 the opportunity to continue to receive reimbursements through the end of the plan year in which participation ceased (including any grace period, taking into account any modification thereto under the Act), under rules similar to those applicable to dependent care FSAs.

Qualifying Child under Dependent Care FSAs. Expenses eligible for reimbursement under a dependent care FSA include those incurred with respect to a qualifying child who has not reached age 13 (if the child is age 13 or older, expenses to care for the child are only eligible for reimbursement if the child is physically or mentally incapable of self-care). The Act enables a dependent care FSA to provide a limited ability to cover the expenses of a child who reaches age 13 either during the plan year for which the regular enrollment period was on or before January 31, 2020, or, to the extent of any unused balance for that plan year, the subsequent plan year.

Change in Election Amount for 2021. Generally, under a health FSA and a dependent care FSA, a participant cannot, during a plan year, change the amount elected for that plan year unless the employee experiences a "change in status." Under prior pandemic-related relief provided by the IRS in Notice 2020-29, plans were permitted to allow election changes during calendar year 2020 without regard to a change in status. Similarly, under the Act, a health FSA and a dependent care FSA may permit an employee to prospectively change the contribution amount elected for the plan year ending in 2021 (but not in excess of any applicable dollar limit), without regard to whether the employee experiences a change in status.

Plan Amendment Deadline. Plan amendments to reflect any of the above provisions of the Act must be 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. Therefore, for example, a sponsor of a calendar year plan who implements any of the above changes with respect to the 2020 plan year must amend its plan by December 31, 2021.

Temporary Rules Preventing Partial Plan Terminations

(Sec. 209 of the Taxpayer Certainty and Disaster Tax Relief Act of 2020)

A substantial reduction in a plan sponsor's workforce can result in a "partial termination" of a tax-qualified retirement plan, requiring full vesting of all affected participants. There is a rebuttable presumption that a partial plan termination occurs when there is a reduction in active plan participation (e.g., due to layoff) of at least 20% during a plan year (or potentially a longer period — for example, if there is a series of related layoffs). Whether a partial plan termination has occurred is determined based on the facts and circumstances, including the extent to which terminations during the applicable period were voluntary, historical employee turnover rates, and whether separate instances of workforce reductions are part of the employer's coordinated plan.

The Act contains helpful relief in assessing and potentially avoiding a plan's partial termination during the COVID-19 pandemic. Specifically, under the Act, a plan is not treated as partially terminated during any plan year that includes the period beginning on March 13, 2020, and ending on March 31, 2021, if the number of active participants covered by the plan on March 31, 2021, is at least 80% of the number of active participants covered by the plan on March 13, 2020. Accordingly, plan sponsors still have time to increase active participation to avoid a pandemic-related partial termination.

Income Exclusion for Employer Payments of Student Loans

(Sec. 120 of the Taxpayer Certainty and Disaster Tax Relief Act of 2020)

The Act enables an employer to contribute up to $5,250 toward repayment of an employee's student loan (for higher education) tax-free to the employee, provided that the payment is made after December 31, 2020, and before January 1, 2026. The employer's payment (including principal and interest) can be made directly to the lender or to the employee. The $5,250 annual cap applies to both the new student loan repayment benefit and other tax-free education assistance (e.g., expenses for tuition, books, and supplies) an employer provides pursuant to IRC § 127. As part of this provision, the interest portion of the payment is not deductible by the employee under IRC § 221. The CARES Act previously permitted such tax-free payment of an employee's student loan, but only for payments made on or after March 27, 2020, and before January 1, 2021.

Special Disaster-Related Rules for Use of Retirement Funds

(Sec. 302 of the Taxpayer Certainty and Disaster Tax Relief Act of 2020)

The Act provides relief with respect to qualified plan distributions and loans taken by a participant or beneficiary whose principal residence during the incident period of a qualified disaster is in a qualified disaster area and who has sustained an economic loss by reason of the qualified disaster (a "qualified individual"). The relief is similar to prior relief under the CARES Act (with respect to the COVID-19 pandemic) and prior IRS disaster-related relief.

A "qualified disaster area" is generally any area where a major disaster was declared by the president during the period beginning on January 1, 2020, and ending on February 25, 2021, if the period during which such disaster occurred (the "incident period" as specified by FEMA) began on or after December 28, 2019, but on or before December 27, 2020. This does not include an area that has been so declared only by reason of the COVID-19 pandemic. Among the many qualified disasters are the California wildfires and Hurricanes Isaias, Sally, and Laura.

Penalty-Free Withdrawal. Under the Act, the 10% early withdrawal penalty that normally applies to qualified plan distributions made before the participant or beneficiary attains age 59½ (subject to limited exceptions, such as in the case of disability, death, or separation from service after attaining age 55) is waived for qualified disaster distributions of up to $100,000 (for all plans of the controlled group, and taking into account all qualified disaster distributions in prior taxable years, but the limitation applies separately with respect to distributions made

for each qualified disaster). The qualified individual may at any time within three years of the distribution re-contribute the amount to a qualified plan or IRA as a rollover. Unless the individual elects otherwise (or timely re-contributes the amount), the income attributable to the qualified disaster distribution is taxed ratably over three years, commencing with the year of distribution. A qualified disaster distribution must be made on or after the first day of the incident period of a qualified disaster and before June 25, 2021.

Re-Contribution of Withdrawals for Home Purchases. The Act allows a defined contribution plan participant who took a hardship withdrawal that was intended to be used to purchase or construct a principal residence in a qualified disaster area but was not so used on account of a qualified disaster in the area where the home was located or to be constructed, to re-contribute the amount to an eligible retirement plan. The individual must have received the hardship withdrawal during the period beginning on the date that is 180 days before the first day of the incident period of the qualified disaster and ending on the date that is 30 days after the last day of the incident period. The re-contribution must be made during the period that begins on or after the first day of the incident period of a qualified disaster and before June 25, 2021.

Temporary Increase in Plan Loan Limits; Delay in Loan Repayment. Generally, a loan from a qualified plan cannot exceed the lesser of (i) $50,000 (as reduced by the excess of the highest outstanding loan balance during the previous year over the outstanding loan balance on the date of the loan) or (ii) 50% of the participant's vested account balance (or, if greater, $10,000). With respect to any plan loans taken by a qualified individual after December 27, 2020, and before June 25, 2021, the Act increases the above dollar limit from $50,000 to $100,000 and increases the above vested account balance percentage limit from 50% to 100%.

For any plan loan of a qualified individual that is outstanding on or after the first day of the incident period, and that has a due date for any payment of the loan during the period beginning on the first day of the incident period and ending on the last day of the incident period, the due date of such payment is extended for one year (or to June 25, 2021, if later), with subsequent payments adjusted to reflect the delay in the due date and any interest accrued during such delay (and such extension period is disregarded for purposes of the maximum five-year term that applies to general purpose loans).

Plan Amendment Deadline. Plan sponsors generally have until the last day of the first plan year beginning on or after January 1, 2022 (i.e., December 31, 2022, for calendar year plans) to amend their plans to provide for this disaster relief. Plan sponsors of governmental plans have an extra two years to amend their plans to provide for this relief.

Protection Against Surprise Medical Bills
(No Surprises Act)

The No Surprises Act seeks to protect group health plan participants from incurring surprise medical bills for services provided by nonparticipating providers or facilities. Several of these protections are briefly highlighted below.

Emergency Services. Plans that offer coverage for emergency services must provide such services without prior authorization requirements, regardless of whether the provider is a participating provider or participating emergency facility (with services of non-participating providers and facilities being made available on a basis similar to participating providers and facilities).

Nonemergency Services. Plans that have a contract with a healthcare facility cannot impose additional cost-sharing requirements for nonemergency services provided by out-of-network providers beyond cost-sharing requirements that would be imposed for similar services performed by an in-network provider at the same facility.

Out-of-Network Services. Additional notification and continued coverage requirements apply to certain participants or beneficiaries receiving services from out-of-network providers at contractually engaged
healthcare facilities.

Primary Care Providers. Plans that require the designation of a primary care provider must permit each participant to designate any participating primary care provider acceptable to the participant. Where the plan requires designation of a primary care provider for a child, the participant may designate any participating physician specializing in pediatric care.

Obstetrical or Gynecological Care. Plans may not require prior authorization or referral for obstetrical or gynecological care provided by a participating healthcare professional with such specialization.

Air Ambulance Services. Plans that provide coverage for air ambulance services may not impose greater cost-sharing requirements for out-of-network providers as would be imposed for in-network providers of such services.

Identification Cards. Plans must include on any insurance identification card issued to participants a clear description of any applicable deductible or out-of-pocket maximum, and a telephone number and website that can be used to obtain consumer assistance.

Price Comparisons. Plans must offer price comparison guidance by telephone and on relevant internet websites so that participants may compare the cost-sharing amounts for services performed by potential providers.

HDHP Status. For plan years beginning on or after January 1, 2022, high-deductible health plans (HDHPs) will not lose their HDHP status by providing medical care coverage as required by the Act.

External Review. No later than January 1, 2022, plans will need to comply with expanded external review processes in the case of adverse benefit determinations and with advance cost-estimate notification and explanation of benefits procedures.

Enhanced Cost Transparency. The Act provides additional protections for participants by enhancing the transparency of service provider claims, cost, and compensation data. For example, group health plans are prohibited from contracting with healthcare providers in a manner that would restrict a plan from providing provider-specific cost or quality-of-care information. In addition, group health plans must comply with revised reporting requirements related to the disclosure of pharmacy benefit coverage and prescription drug costs. Further, group health plans that are subject to mental health parity requirements and impose non-quantitative treatment limitations must conduct comparative analyses confirming parity in the design and application of such limitations.