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Consolidated Appropriations Act, 2021
Health and Welfare Plan Provisions

May 2021

Background

The Consolidated Appropriations Act, 2021 (the "CAA") became law on December 27, 2020. The CAA was widely reported as a COVID-19 relief bill, in part because of its inclusion of $600 direct payments to Americans with an adjusted gross income less than $75,000. However, the Act also includes various employee benefits-related provisions. The following summarizes the Health and Welfare Plan provisions of the CAA.

Expanded Flexibility for Flexible Spending Accounts

The CAA permits employers to amend health and dependent care flexible spending accounts (FSAs) to include the following temporary features:

- Unlimited Carryovers: Health and dependent care FSA participants may carry over unlimited unused balances from the plan year ending in 2020 to the plan year ending in 2021 and from the plan year ending in 2021 to the plan year ending in 2022.
- 12-Month Grace Period: Participants of health and dependent care FSAs that do not permit carryovers may access unused balances at the end of the plan year ending in 2020 or 2021 within 12 months of the end of such plan year.
- Post-Termination Reimbursement: Employees who cease participation in a health FSA during calendar years 2020 or 2021 may receive reimbursements from unused balances through the end of the plan year in which they ceased participation (including any grace period).
- Midyear Election Changes: Health and dependent care FSA participants may make mid-year FSA election changes in the plan year ending in 2021 even without a qualifying change in status.
- Dependent Care FSA Participation for Children Aged 13: Dependent care expenses for children aged 13 or younger (rather than 12 and under) are eligible for reimbursement under a dependent care FSA for the 2020 plan year and, to the extent amounts remain at the end of

the year, for the 2021 plan year. Under previous law, only children aged 12 or younger were eligible.

Plan amendments for FSA changes under the CAA must be adopted by December 31 of the first calendar year beginning after the end of the plan year in which the amendments are effective (e.g., by December 31, 2021 for calendar year plans adopting changes for 2020). The American Rescue Plan Act of 2021 (ARPA) subsequently increased the dependent care FSA contribution limit to $10,500 for the 2021 tax year (or $5,250 for a married participant filing separately). The amendment for this change must be adopted by the last day of the 2021 plan year.

Restrictions on Surprise Medical Billing

The CAA introduces changes aimed at "balance billing" – where patients who had limited control over the choice of their medical provider are billed the balance of the cost of out-of-network medical services not covered by an insurer or medical plan. The changes include the following requirements, generally effective plan years beginning in 2022:

- Plans Must Pay as if In-Network: For out-of-network emergency services, out-of-network services at an in-network facility, and air ambulance services, insurers and plans must impose in-network cost-sharing and count that cost-sharing toward any in-network deductibles and out-of-pocket maximums.

- Restrictions on Surprise Billing: Medical service providers cannot balance bill at out-of-network rates for emergency services, certain ancillary services (such as anesthesiology and radiology) at an in-network facility, or air ambulance services. Balance billing for some non-emergency services can still occur, with advance notice and consent.

- Negotiation and Dispute Resolution: Group health plans and health insurance issuers must pay or deny payment to certain out-of-network providers, establish a 30-day open negotiation period to settle claims with providers, and participate in a binding arbitration process if a rate cannot be agreed upon during the open negotiation period.

- Continuity of Care: If a provider or facility transitions from being in-network to out-of-network, the health plan must notify certain affected participants of the change and ability to get transitional care for an ongoing course of treatment.

- Disclosure Requirements: Group health plans and health insurance issuers must provide certain other disclosures, including insurance ID cards that state in- and out-of-network deductibles and out-of-pocket costs; advance explanations of benefits for scheduled services; a telephonic or online price comparison tool; and updated directories of providers and their network status.

Enhanced Medical Transparency

The CAA adds several requirements intended to enhance health plan transparency for participants and employers:

- Broker and Consultant Fee Disclosure. Brokers and consultants who expect to receive $1,000 or more in direct or indirect compensation must provide fee disclosures to group health plans that describe the services provided to the plan and all direct and indirect compensation.
- Prohibiting So-Called "Gag" Clauses. Group health plans and health insurance issuers may not contract with healthcare providers in a way that would restrict the plans' ability to disclose provider-specific cost or quality of care information.
- Pharmacy Benefit and Drug Cost Disclosure. Plans and insurers must comply with enhanced annual reporting requirements on pharmacy benefit coverage and prescription drug costs.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health plans to provide comparable benefits for mental health and substance use disorders as for medical and surgical care. The CAA further requires plans to analyze and report their compliance with MHPAEA with respect to "non-quantitative treatment limitations" (i.e., limitations other than the cost or number of visits). The Departments of Health and Human Services and Labor are expected to develop a reporting process for this analysis by June 27, 2022.

Contact us. If you have reactions or comments or would like more information, we would be happy to hear from you.