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Client Alert Applies To: Self-Funded, Fully-Funded, Large Group, and Small Group

December 29th, 2020

Provisions of COVID Relief Legislation Applicable To Health and Welfare Plans

The recent COVID-19 relief bill passed by Congress (the Consolidated Appropriations Act of 2021 or "Act") shortly before Christmas and recently signed by President Trump, contains several provisions affecting group health and welfare plans and the employers who sponsor such plans. The relevant provisions are summarized below.

FSA/DCAP Forfeiture Relief

The Act provides relief with respect to flexible spending account (FSA) and dependent care account (DCAP) funds that went unused during 2020. In particular, employers will be allowed, but not required, to permit the following:

- Carryover of unused funds from a plan year ending in 2020 to a plan year ending in 2021;
- Carryover of unused funds from a plan year ending in 2021 to a plan year ending in 2022;
- Where applicable, an employer may extend a grace period for a plan year ending in 2020 or 2021 to 12 months after the end of the plan year;
- Prospective mid-year election changes for any reason – even without a life event – during the plan year that ends in 2021 (note that employers may limit the number of changes or set other conditions, such as prohibiting election changes that would reduce contributions below amounts that have already been reimbursed under a health care FSA);
- Allow participants who terminate employment in 2020 or 2021 to be reimbursed for health care expenses from unused benefits or contributions through the end of the plan year in which their participation ceased (including any grace period);
- Permit use of 2020 DCAP funds (including funds rolled over from 2020 to 2021) for expenses incurred with respect to a 13-year-old child if the child turned 13 during 2020 or 2021.

Plan sponsors seeking to adopt all, or a portion of this relief, generally must amend their plans within twelve months following the end of the applicable plan year.

Surprise Medical Billing

Effective for plan years beginning on or after January 1, 2022, group health plans and health insurance issuers (collectively referred to as "health plans") are required to take certain steps to protect covered persons from surprise medical billing, i.e., billing for costs incurred when an out of-network provider is unexpectedly involved in a participant's care. The Act requires health plans to treat the following services as if they were in-network services: (i) out of-network emergency care, (ii) certain services provided by out-of-network providers at in-network facilities, and (iii) air ambulance services. Any cost-sharing payments made by a participant for these services must count towards the in network deductible and out-of-pocket maximum as if they were performed by in-network providers. The Act also prevents out-of-network providers from balance billing the participant for such services.

By July 1, 2021, the Departments of Labor, the Treasury and Health and Human Services (the "Agencies") must issue rules addressing how health plans must determine the appropriate amount of payment to be made to the non participating provider. If an out-of-network provider disagrees with the amount of its payment, the provider and the health plan must engage in informal discussions followed, if necessary, by binding arbitration.

Transparency Requirements

The Act imposes significant reporting and disclosure requirements on health plans to ensure that covered persons are aware of the different cost-sharing requirements for in-network and out-of-network services, that provider directories are up to date, and that participants are given an advance estimate of costs they can expect to pay for certain scheduled services. These requirements are effective for plan years beginning on or after January 1, 2022 and are in addition to the disclosure requirements imposed by the cost transparency regulations issued earlier this year.

Additionally, one year after the enactment of the Act and by June 1st of each year thereafter, health plans will be required to report certain information to the Agencies regarding prescription drug coverage and costs.

Mental Health Parity Compliance

Within 45 days of enactment of the Act, health plans will be required to perform and document comparative analyses of the design and application of non-quantitative treatment limitations. Health plans will be required to submit these analyses to the Agencies upon request, and the Agencies will be required to request at least 20 analyses per year.

Tax Credit for COVID-Related Paid Sick Leave or Family Leave

Finally, while not relevant to health plans, employers should be aware that the Act did ***not*** extend FFCRA's paid sick and family leave requirements, which expire on December 31, 2020. However, the Act did extend FFCRA's tax credits through March 31, 2021 for employers who voluntarily continue to provide unused FFCRA leave after December 31, 2020 and before March 31, 2021.

Please visit www.moreton.com/news-events/ for more information and to view other client alerts. This Client Alert was written by Carolyn Cox, Moreton & Company's in-house corporate counsel who provides our clients with compliance services. For additional questions, please contact Carolyn at 801-715-7110 or ccox@moreton.com.