

Health Care Provisions in the Consolidated Appropriations Act of 2020 (H.R. 133)

On December 27, 2020, President Trump signed the Consolidated Appropriations Act, which funds the government through September 30, 2021. The \$1.4 trillion legislation includes approximately \$900 billion in COVID relief, and several significant health care provisions.

Surprise Billing

Contained within the CAA is the “No Surprises Act,” which prohibits providers from balance billing patients in certain specific instances. Generally applicable to plan years starting on or after January 1, 2022, group health plans and health insurance issuers must apply in-network cost-sharing to out-of-network emergency services and covered items and services performed by an out-of-network provider at an in-network facility. Cost-sharing amounts paid for these services must count towards the individual’s in-network deductible and out-of-pocket maximum. Plans and issuers must also send initial payment or denial directly to the provider/facility within 30 days. To resolve payment disputes, the CAA creates an IDR process by which a plan or issuer and an out-of-network provider can negotiate and/or arbitrate the payment amount for the furnished item or service. The IDR process involves submission of offers by both sides with the arbitrator choosing one of the offers (i.e. “baseball style” arbitration) and specifies factors that the arbitrator must consider or is prohibited from considering. Finally, air ambulance providers generally cannot send patients surprise bills for more than the in-network cost sharing amount.

Transparency

The CAA contains several provisions related to overall transparency between and among health care stakeholders. Among the various transparency-related provisions, the legislation prohibits gag clauses on price and quality information. Plans and issuers cannot enter into provider contracts that restrict, directly or indirectly, the disclosure of provider-specific cost and quality information. Additionally, the contract cannot restrict plans and issuers from electronically accessing deidentified claims and encounter information for enrollees, including financial information (such as the allowed amount), provider information, service codes, and any other data element included in claim or encounter transactions. Furthermore, contracts cannot restrict plans and issuers from sharing such information with a HIPAA business associate. In addition, the law requires disclosure of agent/broker compensation. Covered service providers must disclose to plan fiduciaries a description of services and any direct or indirect compensation that they reasonably expect to receive for brokerage services or consulting. In an effort to increase transparency regarding PBMs, plans and issuers must annually report to the Secretaries of HHS, Treasury, and Labor detailed information regarding plan spending, the cost of plan pharmacy benefits, enrollee premiums, and any manufacturer rebates received by the plan or issuer.

Health Policy in Transit A Purchaser Viewpoint

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Flexible Spending Arrangements

In general, the CAA expands flexibility in FSAs.

- *FSA Rollovers.* The Act allows health and dependent care FSA participants to carry over unused balances from a plan year ending in 2020 to a plan year ending in 2021 and from a plan year ending in 2021 to plan year ending in 2022. There does not appear to be any maximum carryover amount.
- *FSA Grace Period Extension.* The Act allows a health and dependent care FSA grace period for a plan year ending in 2020 or 2021 to be extended 12 months after the end of such plan year.
- *Health FSA Reimbursements.* The Act permits a health FSA to allow an employee who ceases participation in the plan during 2020 or 2021 (for example, due to termination of employment) to continue to receive reimbursements from unused balances through the end of the plan year in which such participation ceased (including any grace period).
- *Dependent Care FSA Participation.* The Act permits dependent care FSA participants whose qualifying child turned age 13 during the pandemic to continue to receive reimbursements for such child's dependent care expenses for (1) the remainder of the plan year and, (2) to the extent a balance remains at the end of the plan year, the following plan year until the child turns age 14 (but only with respect to the unused amount). The plan year described in (1) must have had a regular enrollment period that was on or before January 31, 2020.
- *FSA Election Changes.* The Act permits health and dependent care FSA election changes for plan years ending in 2021, regardless of whether the employee has a permitted election change event. This extends the election change relief for FSAs provided in IRS Notice 2020-29 by one year.

Mental Health Parity Reporting Requirements

The CAA does not include any new requirements regarding mental health parity, but does contain new requirements for reporting on compliance with mental health parity laws. Plans and issuers must be able to provide the Secretaries of HHS or Labor or a state insurance regulator, as applicable, a detailed analysis regarding compliance with the Mental Health Parity and Addiction Equity Act's (MHPAEA) nonquantitative treatment limitation (NQTL) rule. Analyses must be made available to the applicable authority upon request, which may occur 45 days after the enactment of the Act (**by February 10, 2021**), and should include the factors and evidentiary standards used to determine the NQTL, and the results of the analyses. If the analysis is found to be non-compliant, the plan or issuer must specify the actions it will take to come into compliance and must provide a new, compliant analysis within 45 days. If, after the correction period, the analysis is still determined to be non-compliant, the plan or issuer must inform all enrolled individuals of the non-compliance within seven days.