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Health Care Reform in the Twenties: Appropriations Act Brings Changes for Group Health Plans, Insurers and Providers

In the final days of 2020, the nearly 5,600-page Consolidated Appropriations Act, 2021 (the CAA) became law. The pandemic relief and government spending package includes a myriad of provisions that affect group health plans and insurers. With most health coverage provisions taking effect for the 2022 plan year or sooner, and the CAA's promise of regulations, group health plan sponsors will want to start preparing early. The CAA also included a number of provisions relevant to retirement plans, which are summarized in our prior alert, Appropriations Act Includes Several Provisions Applicable to Qualified Retirement Plans.

Below is a brief overview of the provisions that affect employer-sponsored group health plans. Over the next few weeks, we will prepare in-depth summaries of each provision that identify what is changing and what action steps plan sponsors will need to take. This article will be updated with links as we release those in-depth summaries.

- Temporary Relief for Health and Dependent Care FSAs. Employers may decide to exempt their health or dependent care flexible spending arrangements (FSAs) from the "use-it-or-lose-it" rule for 2020 and 2021. Employers may also make other temporary changes to their FSAs to help employees pay for health care and dependent care.
- Emergency Services, Nonemergency Services by Non-Network Providers at Network Facilities and Air Ambulance Services. The CAA aims to make these services more affordable by limiting cost-sharing and prohibiting balancing billing. The changes affect both grandfathered and non-grandfathered plans under the Affordable Care Act (ACA).
- Rate Negotiations and Independent Dispute Resolution. The CAA's alternative to balance billing is to make the out-of-network provider or facility and the plan or insurer negotiate the charges, or if necessary, go through an independent dispute resolution process.
- Advanced Explanations of Benefits. Insurers and both grandfathered and

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non grandfathered plans under the ACA will need to provide advance cost estimates, which the CAA calls advance explanations of benefits, when enrollees schedule services.

- Price Comparisons. Insurers and non-grandfathered plans will need to offer price comparisons for in-network services by telephone and via an online tool.
- Identification Cards. Health coverage identification cards will need to include any deductibles and out-of-pocket maximums, as well as a telephone number and website for assistance.
- Continuity of Care. The CAA requires that certain high-risk patients who are receiving care when their provider's network changes be allowed to continue that care for a limited time.
- Provider Directories and Network Information. Insurers and plans must maintain up-to-date network provider directories. Otherwise, enrollees might need to pay only the in-network cost sharing for out-of-network services.
- Prohibition Against Gag Clauses on Price or Quality Information. Plan sponsors and insurers will not be allowed to enter into network contracts that include gag clauses on price or quality information.
- Disclosure of Direct and Indirect Compensation for Brokers and Consultants. Brokers and consultants will need to disclose any direct or indirect compensation that they receive for their services related to a plan or insurer.
- Mental Health and Substance User Disorder Benefits. Plans and insurers will need to perform comparative analyses of the nonquantitative treatment limitations that apply to mental health or substance use disorder benefits. These analyses must be made available, upon request, to state authorities or the Departments of Health and Human Services or Labor.
- Reporting on Pharmacy Benefits and Drug Costs. Plans and insurers will need to report information to the federal government annually on their prescription drug benefits and utilization.

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