New Stimulus Legislation Affects Health and Welfare Plans, including Flexible Spending Arrangements

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On December 27, 2020, the President signed into law the Consolidated Appropriations Act, 2021 (the "Act"), the latest major piece of legislation passedby Congress in response to the coronavirus pandemic. This advisory describes certain provisions of the Act affecting health and welfare plans, including health and dependent care flexible spending arrangements ("FSAs"). In a separate advisory, we will describe the Act's impact on retirement plans and other employee benefits.

Temporary Relief for FSAs

As described in our May 20, 2020 advisory, the Internal Revenue Service ("IRS") previously issued temporary relief for FSAs which permitted employers to (a) allow participants to make prospective mid-year election changes during 2020 without regard to the normally applicable rules governing such changes; (b) allow participants to use amounts remaining in an FSA at the end of a plan year or grace period ending in 2020 until December 31, 2020; and (c) increase the carryover limit for applicable health FSAs from $500 to $550.

The Act establishes the following additional temporary relief for FSAs:

- **Expanded Carryovers.** For plan years ending in 2020 or 2021, plan sponsors can allow participants to carry over 100% of their unused balances to the following plan year. This relief applies not just to health FSAs, but also to dependent care FSAs, which ordinarily cannot permit carryovers.

- **Extended Grace Periods.** Plans that include a 2.5 month grace period for using amounts remaining in an FSA at the end of the plan year can extend the grace period to 12 months for plan years ending in 2020 or 2021.

- **Post-Termination Claims from Health FSAs.** Plan sponsors can allow participants in health FSAs whose participation terminates in 2020 or 2021 to continue to receive reimbursements from unused account balances for claims incurred until the end of the plan year in which such participation ceased or, if later, until the end of any applicable grace period or extended grace period.

- **Change to Cut-Off Age for Dependent Care FSAs.** The Act temporarily increases the cut-off age of dependents for whom dependent care expenses are reimbursable from an FSA from age 13 to age 14. This increase only applies to a participant who enrolled in an FSA for the last plan

year for which the open enrollment period ended on or before January 30, 2020 and who had one or more dependents who attained age 13 in such plan year or, if the participant had an unused balance at the end of such plan year, the following plan year.

- **2021 Mid-Year Election Changes.** Plan sponsors can allow participants to make prospective mid-year election changes during 2021 without regard to the standard requirement that there be a qualifying change in status or other applicable event.

Plan sponsors who adopt any of the forgoing relief must amend their plans no later than the last day of the first calendar year beginning after the plan year for which the amendment is effective (e.g., for calendar year plans, the deadline for amending the plan for relief effective as of the 2020 plan year is December 31, 2021). For the amendment to be given retroactive effect, the plan must be operated consistent with the terms of the amendment from the intended effective date.

Additional Provisions Affecting Health and Welfare Plans

- **ERISA Fee Disclosure.** The Act expands the scope of the fee disclosure rules under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to cover service providers who enter into a contract or arrangement with a group health plan to provide brokerage or consulting services for which the service provider reasonably expects to receive $1,000 or more in compensation. Before the contract or arrangement can be entered into or renewed, the service provider must give the responsible plan fiduciary a description of the services to be provided, and all direct and indirect compensation the service provider, an affiliate or a subcontractor reasonably expects to receive for such services. The amendment applies to contracts or arrangements entered into on or after December 27, 2021.

- **Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations.** For plan years beginning on or after January 1, 2022, group health plans and insurers must include, in clear writing, on any physical or electronic plan or insurance identification card, the following information: (1) any deductible and out-of-pocket limitations applicable to the plan; and (2) a telephone number and website address through which the individual may seek consumer assistance information, such as information related to in-network hospitals and urgent care facilities.

- **Price Comparison Tool.** For plan years beginning on or after January 1, 2022, group health plans and insurers must offer price comparison guidance by telephone and maintain a website-based price comparison tool that allows participants to compare the amount of cost-sharing they would be responsible for paying for a specific item or service provided during the plan year by a participating provider in a specified geographic region.

- **Advance Cost Estimates.** For plan years beginning on or after January 1, 2022, group health plans that receive notice of a scheduled procedure from a health care provider or facility must provide an advance explanation of benefits to the participant that includes, among other things, the expected cost of the services, the portion of such cost the plan is responsible for paying, and the network status of the providers.

- **Restrictions on Surprise Medical Billing.** For plan years beginning on or after January 1, 2022, group health plans are prohibited from charging participants out-of-network rates for certain services. First, group health plans that cover emergency services must not bill participants more than the median in-network rate for a particular emergency service, even if the service provider is out-of-network. Second, group health plans are prohibited from billing

participants more than the median in-network rate for nonemergency services provided by out-of-network providers at in-network facilities (unless certain notice and consent requirements are satisfied).

If you have any questions about implementing the temporary relief for FSAs, or if you would like to discuss any other development described above, please contact a member of our Employee Benefits Group.