# Consolidated Appropriations Act of 2021

*December 22, 2020*

**The Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) Is Signed into Law**

*12/27/20 Update:* The President has signed the bill into law. He is sending a strong message to Congress under the Impoundment Control Act of 1974 to freeze funds for up to 45 days for spending to which he objects and wishes Congress to amend. The House will meet on Monday to vote on a bill to pass an increase of recovery rebates to $2,000 for adult taxpayers (and to override the President's veto of the defense spending bill), and the Senate is looking to vote on those measures on Tuesday.

*12/23/20 Update:* In a Twitter video, the President didn't threaten outright veto but expressed some frustrations with how to proceed. "I'm asking Congress to amend this bill and increase the ridiculously low $600 to $2,000, or $4,000 per couple. I'm also asking Congress to immediately get rid of the wasteful and unnecessary items in this legislation or to send me a suitable bill…It really is a disgrace." Congressional leaders welcomed some of his requested changes, but they didn't indicate willingness to change all elements he requested.

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HR 133, the 5,593-page "Consolidated Appropriations Act, 2021," year-end spending bill, includes some $900 billion in its "Coronavirus Response and Relief Supplemental Appropriations Act, 2021." This is by far the longest bill in US history and double the last record holder, the 2,847-page tax reform bill of 1986.

While it doesn't include *everything* the parties wanted, it does include many major elements to provide immediate relief until the next administration and Congress comes in, along with a legislative solution for surprise billing starting in 2022. The bill sailed through both chambers of Congress in just a few hours on Monday, December 21, 2020. It passed 359-53 in the House and 92-6 in the Senate.

The US House of Representatives has provided a 29-page summary, and highlights of some of the included provisions are below. There are some paradigm-shifting transparency changes to health and prescription drug plans that will begin as soon as 2021.

## Temporary Special Rules for Health and Daycare FSAs

- ***Election Changes:*** A health and/or daycare FSA ending in 2021 can allow employees to make an election change without a qualifying event, which is good for a couple reasons we'll explain next
- ***Extended Grace Periods:*** A health and/or daycare FSA ending in 2020 or 2021 with a grace period may extend its grace period to last up to 12 months rather than the usual 2.5 months
- ***Enhanced Carryovers:*** All unused funds remaining in a health and/or daycare FSA ending in 2020 may be carried over to the plan ending in 2021, and similarly all unused funds remaining in a plan ending in 2021 may be carried over to the plan ending in 2022
    - Normally, daycare FSAs can have a grace period but not a carryover, so this exception waives that rule those two years for daycare FSAs that don't already have a grace period
    - This doesn't seem to expressly allow someone to get more than $5,000 of daycare FSA benefits tax-free in a single calendar year, but the employee can be allowed to make a change for the plan year ending in 2021 without a qualifying event
    - And don't forget health FSAs cannot have a grace period and carryover benefit in a single plan year
- ***Terminated Participants:*** A health FSA could allow a participant who ceases participation during calendar year 2020 or 2021 to continue to receive reimbursements from unused funds through the end of the plan year (or subsequent grace period) for the year in which they stopped participating in the health FSA without needing to navigate COBRA
    - Normally, this would only be available for daycare FSAs
- ***HSA Eligibility:*** Side note that any health FSA carryovers or extended grace periods might block eligibility to contribute to a health savings account (HSA), even if the funds are spent relatively quickly into the new year or grace period, so in those situations a limited-purpose FSA may work better
- ***Child Aged Out:*** A daycare FSA could allow someone enrolled in a plan year that began on/before January 31, 2020 a couple of options related to their child that may have turned 13 or is about to turn 13:
    - They could reimburse themselves for dependent care expenses incurred during the remainder of the plan year after the child turned 13
    - If they have funds left at the end of the plan year, those specific leftover funds could continue to be used in the next plan year on a child that turned or is turning 13, but not past the child turning 14

- ***Plan Amendment Required:*** All of the above provisions are optional, but if you decide to adopt one or more of them, be sure to update your plan accordingly. The Act gives you special permission to draft changes retroactively so long as they're "adopted by the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective"
    - For example, a calendar year plan adopting changes for 2020 to carry over the full unspent balance into 2021 or to extend the 2021 grace period would have until December 31, 2021, to formally adopt the amendments, but should operate the plan in the meantime as if the amendments are in effect

**"Continued Assistance for Unemployed Workers Act of 2020" (extending support through March 14, 2021)**

- Keeps providing states with statutory Short-Time Compensation ("worksharing") programs full financing *(and other states with non-statutory, temporary worksharing programs 50% financing)*
- Extends Pandemic Unemployment Assistance (PUA) from 39 to 50 weeks
    - Potentially lasting to a week beginning on/before April 5 for individuals eligible on the March 14 end date that haven't exhausted their time limits
    - Provides retroactive payments to weeks of unemployment after December 1, 2020 for new applicants
    - Imposes new requirements for states to verify identities
    - Effective January 31, 2021, individuals must submit additional substantiation documents
- Restarts the Federal Pandemic Unemployment Compensation (FPUC) supplement at $300 per week starting after December 26, 2020, and increases the maximum number of weeks from 13 to 24 weeks
- Extends federal funding for states that waive the "waiting week" *(someone's first week of unemployment)*, but the full reimbursement to states will be reduced to 50% for weeks ending after December 31, 2020
- Requires states to implement additional measures within 30 days to address situations of individuals refusing to return to work or accept an offer of suitable work

**"COVID-related Tax Relief Act of 2020"**

- Second round of refundable tax credits to individuals, paid in advance as soon as the week after Christmas
    - $600 per taxpayer and qualifying child
    - Phased out $5 per $100 of income over $75,000 adjusted gross income ($112,500 head of household, $150,000 married filing jointly)

- For employers that may have deferrred Social Security withholdings September 1, 2020 through December 31, 2020, per the President's executive memorandum, the withholding of those deferrals previously due by April 30, 2021, is now extended to December 31, 2021
- For January 1, 2021 through June 30, 2021, extends the Employee Retention Credit to 70% on up to $10,000 in wages per quarter *(the original ERC gave 50% credit on up to $10,000 for the 2020 year, not per quarter)*
- Extends FFCRA paid leave 100% tax credits through March 31, 2021
    - This does not extend the requirement to honor EPSL or EFML requests past the December 31, 2020, end date
    - This merely allows an employer in the private sector with fewer than 500 employees to keep offering such leaves if they wish through March 31, 2021, with 100% tax credits to pay for it *(noting it's still a total of 80 hours EPSL and up to 12 weeks EFML, including any voluntarily honored dates in 2021)*

**"Economic Aid to Hard-Hit Small Businesses, Nonprofits, and Venues Act"**

- Certain shuttered live venue operators/promoters, theatrical producers, live performing arts organization operators, relevant museum operators, motion picture theatre operators, or talent representatives may qualify for grants
- Provides a "PPP second draw" opportunity for particularly hard hit employers with fewer than 300 employees and a 25% year-over-year quarterly reduction in gross receipts
- Retroactive to the start of the CARES Act, any loan forgiveness under PPP and certain other emergency SBA forgiven loans and grants will not be considered gross income, and expenses paid with a forgiven loan will remain deductible business expenses *(rather than being treated as an impermissible double-dip that once forgiven has already been tax advantaged and would have no longer been deductible)*
    - Also adds new categories of allowable, forgivable expenses retro to the start of the CARES Act, along with other changes like being able to include dental, vision, life, and disability premiums in payroll costs
    - Requires a simplified forgiveness application process to be developed within 24 days of the Act becoming law for loans up to $150K
    - Employers that didn't previously qualify for loan forgiveness may have a second chance to apply given the new retroactive changes
    - Employers that could've qualified for more funds given the new retroactive changes can also apply for the extra funds

The bill also provides:

- The "Coronavirus Economic Relief for Transportation Services Act" which may help providers of transportation services
- The "Motor Carrier Safety Grant Relief Act of 2020" which may help recipients of financial assistance awards from the Federal Motor Carrier Safety Administration
- Extensions of rental assistance and eviction moratoriums
- The Main Street Lending facility will end December 31, 2020

**"Taxpayer Certainty and Disaster Tax Relief Act of 2020"**

- Permanently lowers the medical expense deduction floor from the ACA's 10% to the pre-ACA level of 7.5%, effective 2021
- Increases the 50% deduction for business meals to 100% for 2021 and 2022
- The Work Opportunity Credit is extended five years to December 31, 2025
- The Paid Family and Medical Leave tax credit under §45S is extended five years to December 31, 2025
- Qualified employer educational assistance programs can keep employee student loans as an eligible expense for five more years through plan years ending on/before December 31, 2025 (still capped at $5,250/yr for all eligible educational expenses combined)

**The "No Surprises Act" (effective plan years on/after January 1, 2022)**

- Medical plans cannot require pre-authorization for emergency services in an emergency room *(whether free-standing or in a hospital)*
- Medical plans with emergency services claims in such an emergency room that is out-of-network may not apply extra restrictions/limitations beyond what would apply in-network, may not impose cost-sharing greater than would apply in-network (and must calculate the cost-sharing as if median contracted rates had been charged), must count cost-sharing toward in-network accumulators such as deductibles and out-of-pocket limits, must make initial payment or declination within 30 days, and will negotiate the balance bill in accordance with the Act without involving the patient
    - Services in 2022 would use the median contracted rate from January 31, 2019, from that insurer's respective large group, small group, or individual market within a geographic region, indexed by CPI-U to January 31, 2020 and again to January 31, 2021
    - Services in 2023 and forward would then index annually by CPI-U to the previous year's January 31
- Out-of-network providers furnishing services as part of an in-network treatment will be subject to new requirements

    - A specific disclosure of required elements, including non-network status and pricing, to the patient at least 3 days before services are to be rendered, with signed consent approving such services, in order to preserve the ability to balance bill the patient
    - In the absence of proper disclosure or consent, the provider can only charge the member in-network cost-sharing (calculated as if median contracted rates had been charged) and cannot balance bill the patient (and the plan must apply such cost-sharing toward in-network accumulators such as deductibles and out-of-pocket limits, make initial payment or declination within 30 days, and pays the balance bill in accordance with the Act)
- Out-of-network rates might be regulated by a State's own insurance law or a State's All-Payer Model Agreement under section 11115A of the Social Security Act; for other states, it could be an agreed upon rate via open negotiation or, as a last resort, via a new independent dispute resolution (IDR) process *(a formal arbitration construct which all parties will agree to without patient involvement)*
- After initial payment or denial within 30 days, the health care provider will then have 30 days to conduct an open negotiation. If they reach the end of those 30 days without a mutual resolution, the parties then have 4 days to initiate an IDR, which involves:
    - A formal proposal to the Secretary of Health and Human Services (HHS)
    - HHS then has 3 business days to offer the parties a list of independent certified IDR entities
    - The parties will then have 6 business days from their initial submission to choose their IDR arbiter or be assigned one if they can't jointly choose one in time
    - The parties will then have 10 days to submit to the certified IDR entity their balance billing offer with information the IDR requires along with any other relevant supporting information
    - The IDR entity will have 30 days from initially accepting the assignment to take into account each party's offer and notify all parties of its binding determination which shall generally not be subject to judicial review
    - The IDR entity should take into consideration typical payments accepted in that geographic region; level of the provider's training, experience, quality and outcomes measurements; market share for all parties; acuity of the patient's condition and complexity of care; teaching status, case mix, and scope of services of a non-participating facility involved in providing the care; demonstrations of good-faith efforts (or lack thereof) to enter into a network agreement during the previous four plan years
    - The IDR entity is prohibited from considering usual and customary charges; the charge that would have been billed in the absence of this law; or

amounts that would be reimbursed under public programs like Medicare, Medicaid/CHIP, or TRICARE

- Once an IDR arbitration is final, the party that requested the IDR may not submit another IDR for the parties/services involved for the next 90 days following the decision
- All IDR activity will be subject to public reporting (without disclosing protected health information) to promote transparency and will be subject to fees by those utilizing the services
- Regulators will be required to provide formal rulemaking on surprise billing provisions by July 1, 2021 *(but will have one year to establish IDR regulations)*
- These surprise billing rules:
    - Will not cause anyone eligible to contribute to an HSA to become ineligible
    - Will apply to air ambulance providers (with certified IDR entities also taking into account the ambulance vehicle type and clinical capabilities and the population density of the pick up location)
        - Creates a new Advisory Committee on Air Ambulance Quality and Patient Safety within 60 days of the Act becoming law, with its first meeting to be held within 90 days of the Act becoming law *(a similar path also establishes an Advisory Committee on Ground Ambulance and Patient Billing)*
    - Will apply to grandfathered plans
    - Will require providers that leave a network to communicate with patients under continuing care about the change in network status and an option to continue care for up to 90 days as if the provider had remained in-network
    - Will be jointly enforced by the State and HHS

## Health Plan Transparency Measures

These seem to tie in closely with the final transparency rules we recently saw (effective 2021 for hospitals and ambulatory surgical centers, and in 2022 for health plans and insurers).

- Medical plans will have to start clearly disclosing on physical and electronic ID cards the in- and out-of-network deductible and out-of-pocket requirements along with the phone and website for consumer assistance determining network provider participation
- Medical plans will have to maintain a price comparison tool via phone and web, maintain accurate provider directories on their website which are updated within two business days of a provider/facility change and are verified every 90 days, and maintains records for two years after each request for network information to prove

they responded to each and every phone/mail/email/web request within one business day
    - If a member relies on provider participation data from the means discussed above that turned out to be inaccurate, the plan will likely have to honor the claim as in-network
    - Print directories should indicate it's accurate as of the date of publication along with instructions on how to retrieve/request the most current information
- Medical plans will have to provide advance explanation of benefits with cost estimates within one business day of a request (or within three business days if a service is scheduled at least 10 business days out) with clear and easy to understand language as follows:
    - A participating provider's contracted rate (based on the billing and diagnostic codes submitted)
    - In the case of a non-participating provider, a description of how to obtain information on in-network provider access
    - A good faith estimate from the provider based on the codes submitted
    - A good faith estimate of the plan's coverage amount, the member's cost-sharing, and any deductible and out-of-pocket requirements already met as of the date of the notice
    - Explanation of any medical management techniques applicable to these services
    - A disclaimer this is a good faith estimate on items/services reasonably expected to be furnished, and is subject to change
    - As well as any other valid disclaimers/information the plan deems appropriate to disclose
- Group health plans (and their insurers) will have to annually attest to HHS that they are no longer engaged in provider/network agreements that would directly or indirectly restrict the group health plan from:
    - Providing provider-specific cost or quality of care data, via consumer engagement tools or to referring providers, the plan sponsor, enrollees, or individuals eligible to enroll *(the provider/network can, however, place "reasonable restrictions on the public disclosure" of such information)*
    - Accessing de-identified claim by claim data with detailed financial info (allowed amount or any other claim-related financial obligation included in the provider contract), provider info (name, clinical designation), service codes, or any other data element included in claim/encounter transactions
    - Sharing all such data above (or directing sharing of that data) with a HIPAA business associate

- In concert with these rules, Congress hereby orders federal regulators to issue proposed rules on protections against provider non-discrimination no later than January 1, 2022, followed by a 60-day comment period and issuance of a final rule within 6 months after that, and to start requiring network adequacy reporting
    - At this point, these rules required by the Affordable Care Act (ACA) 10 years ago have been under a good faith standard without issuance of formal rules
    - But the ability for a provider to demonstrate good faith efforts to negotiate with a network is a fundamental element of a successful IDR negotiation
    - So Congress is placing a renewed emphasis on the need for regulators to comply with issuing regulations required by the ACA over 10 years ago
- Congress is extending grants to states that want to implement/improve a State All Payer Claims Database, with $1 million the first year, $1 million the second, and half a million the third year

## More Transparency under the Mental Health Parity and Addiction Equity Act (MHPAEA)

- Medical plans with mental health or substance use disorder benefits that impose nonquantitative treatment limitations (NQTLs) must perform and document comparative analyses of the design and application of NQTLs and make them available to the State or to federal agencies upon request, starting 45 days after the Act becomes law
- Should the state or federal authority find a plan non-compliant, a 45-day corrective action period will commence, and if the plan should fail to comply then the state or federal authority will notify all plan members of the non-compliant plan provisions
- HHS shall submit annual reports to Congress of these NQTL inquiries, analyses, and corrective action remedies
- HHS must publish a final rule within 18 months addressing these elements and clarifying how to file NQTL complaints
- Federal agencies must update the MHPAEA compliance guidance document every two years to include illustrative, de-identified examples of actual compliant and non-compliant NQTLs

## More Transparency: New Annual Prescription Drug Reporting

- Within one year of the Act becoming law, and by every June 1 thereafter, group health plans (or their insurers), except for church plans, must submit to the secretaries of HHS, DOL, and Treasury a de-identified report of the previous plan year's:
    - Plan year dates
    - Number of enrollees

    - States in which the plan is offered
    - The 50 brand drugs most frequently dispensed under the plan, with the total number of paid claims for each of those drugs
    - The 50 most costly prescription drugs under the plan's total annual spending, with the total amount spent for each of those drugs
    - The 50 prescription drugs with the greatest increase in plan expenditures plan year over plan year, with change in amounts for each of those drugs
    - Total spending on health care services by the plan, broken down by:
        - The type of costs, including hospital costs, primary care costs, specialty care costs, prescription drug costs, and other medical costs including wellness services
        - Spending on prescription drugs by the health plan vs. enrollees
    - Average monthly premiums paid by employers vs. enrollees
    - Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers, including:
        - Amounts paid for each therapeutic class
        - Amounts paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration
    - Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration
- HHS will then biannually provide a report of prescription drug trends (without identifying plans or individuals)