Law/Guidance	Summary	End-of-Year Action Items
Permissible Flexibility under Code Section 125 Pursuant to IRS Notice 2021-15	Notice 2021-15 offered plan sponsors the flexibility to adopt any of the following options despite the longstanding rules under Section 125 of the Code: • Carryover of unused amounts in a Healthcare Flexible Spending Account (HCFSA) and Dependent Care Flexible Spending Account (DCFSA) from the 2020 and 2021 plan years into the 2021 or 2022 plan years, respectively. • Extension of an existing grace period (instead of a carryover) for a plan year ending in 2020 or 2021 for 12 months after the end of the plan year for both an HCFSA and a DCFSA. • Permitting prospective election changes to HCFSA and DCFSA elections for plan years ending in 2021 without regard to a change in status opportunity. • Permitting prospective election changes under employer-sponsored group health plan coverage absent a change in status opportunity (limited to medical, dental, or vision coverage). • Spending down unused contributions for participants who ceased participation in an HCFSA during the year through the end of the year that participation ceased. • Extending the DCFSA definition of an eligible dependent child age to under age 14, allowing participants to receive reimbursement for expenses for qualifying dependents who aged out during the plan year (if the enrollment period ended before January 31, 2020, and the eligible dependent child aged out of coverage during the 2020 plan year).	Plan sponsors that made any of the permissible opportunities described under Notice 2021-15 available to participants must amend their plans by the end of the first calendar year beginning after the plan year the amendment was effective. This means calendar year plan amendments effective in 2020 must be adopted by December 31, 2021.

Law/Guidance	Summary	End-of-Year Action Items
	For more information, refer to the LawFlash **Consolidated Appropriations Act, 2021: Health And Welfare Provisions.** ***Also, see the Lawflash*** **IRS Gymnastics With Code Section 125 for FSAs: Notice 2021-15.**	
Mental Health Parity Transparency	The Consolidated Appropriations Act, 2021 (CAA) requires group health plans that offer both medical and surgical benefits as well as mental health or substance use disorder benefits that impose nonquantitative treatment limitations (NQTLs) (e.g., medical management standards, formulary design for prescription drugs, fail-first policies or step therapy protocols) on mental health or substance use disorder benefits to perform and document comparative analyses of the design and application of NQTLs. The analyses must include the following: • The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification. • The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits. • The evidentiary standards used for the factors identified above when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.	Plan sponsors now have a statutory obligation to ensure that the comparative analyses for NQTLs are performed and should work with their third-party administrators and take steps internally, as necessary, to ensure they are ready to demonstrate compliance with these new requirements. Additional regulations are expected in 2022.

Law/Guidance	Summary	End-of-Year Action Items
	• The comparative analyses demonstrating that the process, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification. • The specific findings and conclusions reached by the group health plan with respect to the health insurance coverage that indicate the group health plan is or is not in compliance. This new statutory obligation became effective on February 10, 2021. ***For more information, see the ML BeneBits blog post* Mental Health Parity Transparency: Consolidated Appropriations Act, 2021.**	
No Surprises Act	The No Surprises Act is intended to prevent surprise medical bills for emergency services, air ambulance services, and non-emergency services provided by out-of-network providers at an in-network facility. The regulators released two Interim Final Rules implementing these requirements thus far: • "Part I" focuses on how the surprise billing protections apply to group health plans and issuers and specifies the methodology used to calculate the "Qualified Payment Amount." This IFR also requires plans and issuers to disclose certain information	To comply with the requirements under the No Surprises Act, plan sponsors of self-insured group health plans must be prepared before January 1, 2022 to: • Work with their third-party administrators (TPAs) to ensure that coverage for emergency services, air ambulance services, and non-emergency services provided by out-of-network providers at an in-network facility will be provided in accordance with guidance. • Comply with the disclosure requirements by posting the model notice and coordinating with

Law/Guidance	Summary	End-of-Year Action Items
	about the restrictions on balance billing and other No Surprises Act protections publicly, post on the plan's/issuer's public website, and include such information on each explanation of benefits (EOB) for an item or service. The regulatory agencies have issued a model notice to facilitate compliance with these requirements, and consider use of the model notice to be "good faith compliance" with the disclosure requirement until further guidance is issued. ***For more information, see the LawFlash*** **Biden-Harris Administration Issues Part I of Surprise Billing Rule.** • "Part II" provides guidance related to the independent dispute resolution process (between the plan/issuer and provider/facility) to determine the out-of-network payment rates.	TPAs to ensure that the model notice is included in EOBs. • Determine whether and to what extent the plan's TPAs will assist with the independent dispute resolution process.
Additional Transparency Requirements	The regulatory agencies issued frequently answered questions (FAQs) addressing the implementation of some provisions of the Affordable Care Act and transparency requirements under the CAA delaying the effective dates of certain transparency requirements. The following requirements were not delayed and remain effective for January 1, 2022 (unless otherwise noted below): • Including deductibles and out-of-pocket maximums on insurance identification cards. • Prohibiting gag clause provision in contract for provider cost or quality of care information.	Many of the transparency requirements effective January 1, 2022 will require a good faith reasonable interpretation given that regulatory guidance has not yet been issued. Plan sponsors should work with their TPAs to ensure that the proper steps are being taken toward compliance.

Law/Guidance	Summary	End-of-Year Action Items
	• Establishing processes to update and verify provider directory information and establishing protocols to respond to participants' requests regarding provider network participation status. • Continuation of care in instances where terminations of relationships result in changes in the provider or facility network status. • Posting public machine-readable files for in-network provider rates. Note the effective date for this requirement was extended to July 1, 2022. • Posting public machine-readable files for out-of-network allowed amounts/billed charges for covered items. Note the effective date for this requirement was extended to July 1, 2022. ***For more information, see* FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49.**	
COBRA Subsidy Under the American Rescue Plan Act (ARPA)	Under the ARPA, terminated employees who met certain criteria became eligible to receive a premium subsidy for 100% of the cost of COBRA for up to a six-month period from April 1, 2021, through September 30, 2021. Under the guidance, premium payees who provided the subsidy (generally multiemployer plans, plan sponsors of self-insured group health plans, and insurers for the fully insured group health plan), are eligible for the subsidy tax credit. ***For more information, see the LawFlash* IRS Issues Guidance Regarding American Rescue Plan Act Cobra Subsidy.**	Premium payees that provided the ARPA COBRA subsidy may claim a tax credit on quarterly tax returns (Form 941) to receive the applicable tax credit.

Law/Guidance	Summary	End-of-Year Action Items
	Also see the ML BeneBits blog post **IRS Provides Second Round of FAQs on Cobra Subsidies.**	