# Consolidated Appropriations Act of 2021 – Important Provisions and Effective Dates

The Consolidated Appropriations Act of 2021 (CAA) was signed into law in December 2020 and contains important provisions related to health plan transparency, applicable to health plans and insurers, including the No Surprises Act.

Plan sponsors are advised to review the CAA important provisions and effective dates that are outlined in the reference chart below for application to their health plans. Until the relevant federal agencies issue further rules or guidance related to these CAA provisions, group health plans and insurers are expected to comply with the CAA provisions using a good faith, reasonable interpretation of the law.

Please reach out to your Risk Strategies account team with any additional questions.

| CAA Provision | Description | Applicable To | Effective Date | Notes |
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| **Plan ID Cards** | **Plans are required to include the following plan-related information on any physical or electronic plan ID card:**<br>**1. Deductible**<br>**2. Out-of-Pocket (OOP) maximums**<br>**3. Consumer assistance information including a phone number and website** | **Group health plans and health insurers** | **Plan years beginning on or after January 1, 2022** | |
| **No Surprises Act – Emergency Services** | **Plan participants cannot be charged more than the in-network cost-sharing amount (deductibles, copayments, coinsurance) for the following out-of-network services:**<br>**1. Most emergency services, including ancillary services and post-stabilization services.**<br>**2. Non-emergency services, such anesthesiology or radiology, provided by out-of-network providers when received at an in-network facility.**<br>**3. Air ambulance services** | **Group health plans and health insurers** | **Plan years beginning on or after January 1, 2022** | **Prohibits "balance billing" by providers and facilities** |

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| No Surprises Act – Independent Dispute Resolution | New binding arbitration process, which is an independent dispute resolution (IDR) process involving a neutral third-party that settles out-of-network service cost disputes between the provider and the health plan. | Group health plans and health insurers | Plan years beginning on or after January 1, 2022 | The plan participant is not involved in the IDR process and is only responsible for the in-network cost-sharing amount regardless of the final IDR reimbursement amount.<br>NOTE: On February 23, 2022, a federal district court in Texas invalidated certain portions of the IDR process under the No Surprises Act. The DOL issued a subsequent memo on February 28, 2022, confirming that these invalidated portions of the IDR process are being withdrawn at this time. |
| Group Health Plan Transparency Rule | Plans are required to disclose online publicly the following information using machine-readable files:<br>1. In-network rates<br>2. Out-of-network allowed amounts | Non-grandfathered health plans and health insurers | Enforcement delayed until July 1, 2022 | Does not apply to grandfathered plans, account-based plans (FSAs, HRAs), excepted benefits (dental and vision plans), short-term limited duration medical insurance or retiree-only plans |
| Group Health Plan Transparency Rule - Rx | Plans are required to disclose online prescription drug negotiated rates using machine-readable files | Non-grandfathered health plans and health insurers | Enforcement deferred until future rules are promulgated | Does not apply to grandfathered plans, account-based plans (FSAs, HRAs), excepted benefits (dental and vision plans), short-term limited duration medical insurance or retiree-only plans |
| Group Health Plan Transparency Rule – Disclosures to Plan Participants | Plans are required to provide accurate cost-sharing and rate information upon request by a plan participants. This information will be accessed by plan participants from a searchable, internet-based self-service tool. | Non-grandfathered health plans and health insurers | Plan years beginning on or after January 1, 2023 for 500 items/services<br><br>Plan years beginning on or after January 1, 2024 for all items/services | Does not apply to grandfathered plans, account-based plans (FSAs, HRAs), excepted benefits (dental and vision plans), short-term limited duration medical insurance or retiree-only plans |
| Provider Fee Estimate | When a patient schedules a service/procedure, providers and facilities are required to provide a | Healthcare providers and facilities | Enforcement deferred until future rules are promulgated | |

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| | notification to the plan or individual with the good faith estimate of the expected charges for providing the service/procedure with the expected billing and diagnostic codes. | | | |
| Advanced Explanation of Benefits (EOB) | Upon receipt of estimated charges from a provider/facility, plans must provide the participant with an advanced EOB containing:<br>1. rate information<br>2. cost-sharing details<br>3. network status of the provider/facility.<br>4. Disclaimer language indicating if the coverage is subject to medical management techniques. | Group health plans and health insurers | Enforcement deferred until future rules are promulgated | |
| Notice of Continuity of Care | Plan participants who qualify as "continuing care" patients must be notified of their right to continue to receive care after termination of a provider/facility contract for up to 90 days as if they were still covered by the plan on an in-network basis. | Group health plans and health insurers | Plan years beginning on or after January 1, 2022 | Continuity of care protections apply to patients who are already receiving care or treatment from the provider/facility for any of the following:<br>1. serious and complex condition<br>2. institutional or inpatient care<br>3. scheduled for non-elective surgery<br>4. pregnant<br>5. terminally ill |
| Price Comparison Tool | Plans/insurers are required to offer a price comparison tool on their public website that allows a plan participant to compare the amount of cost-sharing that the participant would be responsible for paying for items/services by an in-network provider, by geographic region. | Group health plans and health insurers | Plan years beginning on or after January 1, 2023 | |
| Provider Directory | Plans must verify that their in-network provider directories are accurate and updated every 90 days. If a plan participant | Group health plans and health insurers | Plan years beginning on or after January 1, 2022 | Plans/insurers must also respond to participant requests regarding a provider's network status within one |

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| | relied on inaccurate provider network status information from the plan/insurer when receiving services from an out-of-network provider/facility, the plan is required to apply in-network cost-sharing amounts along with the in-network deductible and out-of-pocket maximum in those instances. | | | business day of the request and establish a database of in-network providers. |
| Prohibition on Gag Clauses | Prohibits health plans/insurers from entering into certain agreements, particularly those involving a provider network, that impose certain restrictions on the plan's access and ability to share information about the cost and quality of care. Requires annual attestation of compliance. | Group health plans and health insurers | December 27, 2020 | Attestation requirements to begin in 2022 and guidance is expected. |
| Mental Health Parity and Addiction Equity Act (MHPAEA) Analysis | Plans/insurers are required to complete a comparative analysis of the plan's nonquantitative treatment limitation (NQTL) design, application and rules, and provide to the DOL or HHS upon request | Plans subject to MHPAEA | February 10, 2021 | |
| Prescription Drug Costs Reporting | Plans must disclose prescription drug cost information to the federal government. | Group health plans and health insurers | Delayed until December 27, 2022 | |