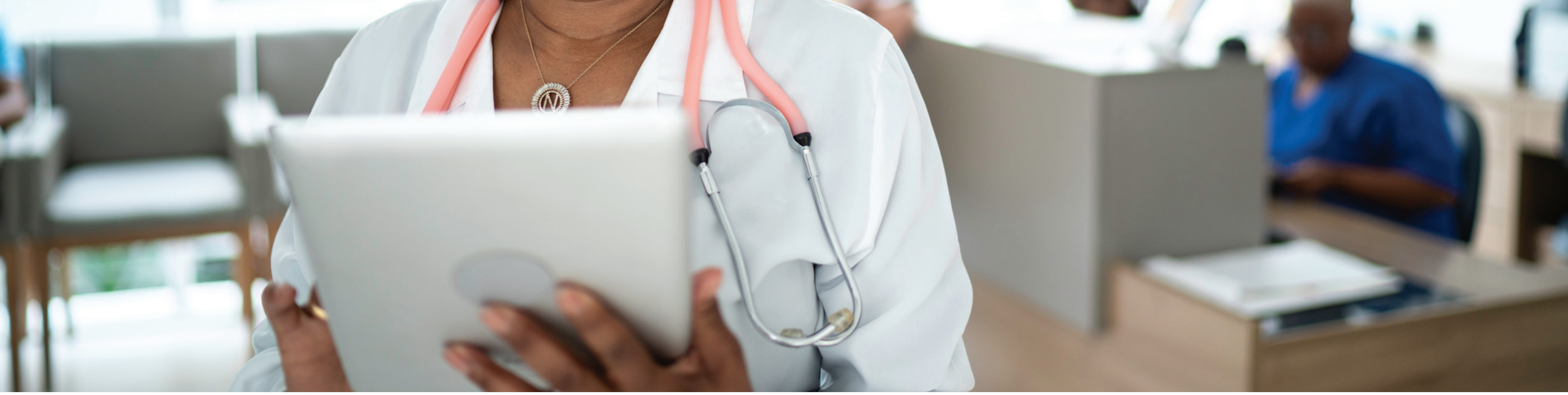

CAA Provision Status Update

September 10, 2021

The Consolidated Appropriations Act of 2021 (the "CAA") was signed into law on December 27, 2020 and includes several provisions impacting group health plans and health insurance issuers. Below is a summary of the most pertinent pieces and the status of its implementation or effective date.

CAA Provision and Section	Summary	Original Effective Date	Status
Mental Health Parity, Section 203	Requires health plans to perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) to be provided upon request to federal regulators and plan participants	February 10, 2021	In effect on February 10, 2021. Employers sponsoring self-insured health plans should have Self-funded employers should put plans in place to complete the analyses either pro-actively or upon receipt of a DOL audit letter.
Insurance ID Cards, Section 107	Requires plans and carriers to include on any physical or electronic plan or insurance identification card issued to participants, beneficiaries or enrollees any applicable deductibles, out-of-pocket maximum limitations and a telephone number and website address for consumers seeking consumer assistance. The information is required to be provided in clear writing.	Effective for plan years beginning on or after January 1, 2022.	The agencies do not intend to issue rules related to this requirement before January 1, 2022 and, therefore, plans and carriers must begin to comply with these requirements by that date. Plans and carriers are expected to determine how to represent plan and coverage designs in a compliant way on the ID cards using a good faith, reasonable interpretation of the law.

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CAA Provision and Section	Summary	Original Effective Date	Status
Balance Billing Disclosure Requirements, Sections 104 & 105	Amends the Public Health Service Act to require, in certain circumstances, plans and providers (including hospitals, facilities, individual practitioners and air ambulance providers) are prohibited from billing patients more than in-network cost-sharing amounts. The prohibition applies to both emergency care and certain non-emergency situations when patients are unable to choose an in-network provider. Plans must provide notices to participants disclosing the prohibition on surprise billing and provide contact information in the event the rules are violated.	Effective for plan years beginning on or after January 1, 2022.	Effective for plan years beginning on or after January 1, 2022. The DOL has provided a model notice and has indicated more guidance will follow.
Advanced Explanation of Benefits (Advanced EOBs), Section 111	Requires group health plans and carriers to send (via mail or electronically) a participant, beneficiary or enrollee an Advanced EOB in clear and understandable language that includes certain specified information, including (1) the network status of the provider or facility, (2) the contracted rate (for participating providers or facilities) or a description of how a participant can obtain information about participating providers or facilities, (3) good faith estimate received from the provider or facility, (4) a good faith estimate of the participant's cost-sharing and the plan's responsibility for paying for the items or services and (5) information regarding any medical management techniques that apply to the items or services.	Effective for plan years beginning on or after January 1, 2022.	The DOL intends to engage in notice-and-comment rulemaking in the future to implement these requirements, including establishing appropriate data transfer standards. Accordingly, the DOL will defer enforcement but did not specify a specific compliance date.

CAA Provision and Section	Summary	Original Effective Date	Status
Provider Directories, Section 116	Amends the Public Health Service Act to establish provider directory standards, which require plans or carriers to establish a process for updating and verifying the accuracy of information in their provider directories and establish a protocol for responding to telephone calls and electronic communications from participants, beneficiaries or enrollees about a provider's network participation status and must honor any incorrect or inaccurate information provided to the participant, beneficiary or enrollee about the provider's network participation status.	Effective for plan years beginning on or after January 1, 2022.	Rulemaking to come. Plans and carriers must comply with these requirements and will not be considered to be out of compliance if, (1) beginning on or after January 1, 2022, in situations where a participant, beneficiary or enrollee receives items and services from a non-participating provider and the individual was provided inaccurate information by the plan or issuer via the provider directory or response protocol indicating the provider was participating and (2) the plan or issuer imposes only a cost-sharing amount that is not greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider and counts those cost-sharing amounts toward any deductible or out-of-pocket maximum. Once implemented, the final rules will have a prospective effective date.
Broker Compensation Transparency, Section 202	Amends Section 408(b)(2) of ERISA and creates new transparency requirements that impact group health plans and their brokers or consultants. Specifically, group health plans must receive disclosures from brokers or consultants (or their affiliates or subcontractors) who reasonably expect to receive $1,000 or more (indexed for inflation) in direct or indirect compensation in connection with providing certain designated insurance-related services for the group health plan. The disclosures include description of the services, a description of direct compensation and a description of indirect compensation, including a finder's fees.	In effect for all contracts or covered services executed or renewed on or after December 27, 2021.	In effect for all contracts or covered services executed or renewed on or after December 27, 2021.

CAA Provision and Section	Summary	Original Effective Date	Status
Pharmacy Transparency, Section 204	Requires group health plans or issuers to begin reporting information regarding health plan coverage to the IRS, HHS and DOL. The required information is extensive and includes: the 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan and the total number of claims for each such drug; the 50 prescription drugs with the greatest increase in plan expenditures over the plan year before the plan year in which the report pertains, including the amounts expended by the plan for each drug during such plan year; and total spending on healthcare serviced by the plan, broken down by hospital costs, healthcare provider and clinical service costs for both primary care and specialty care prescription drug costs, other medical costs (including wellness services) and spending on prescription drugs by the health plan and enrollees.	The first report is due on December 27, 2021 (one year after enactment of the CAA), while each subsequent annual report is due by June 1st.	Plans will be required to file their first report on December 27, 2022, and each June 1st thereafter. The agencies encourage plans and carriers to amend contracts and put processes and procedures in place to ensure they can meet the initial December 27, 2022, deadline.
Gag Clauses, Section 201	Removes gag clauses on price and quality information. Providers, networks or associations of providers, TPAs or other service providers are prohibited from either directly or indirectly restricting (by agreement) plans or carriers from providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries or enrollees or individuals eligible to become participants, beneficiaries or enrollees of the plan or coverage; among other requirements. Further, plans and carriers are required to submit an annual report to the DOL, HHS or IRS confirming compliance with these requirements.	December 27, 2020	The DOL believes these requirements are self-implementing and does not expect to issue any regulations on these requirements, though they will release guidance regarding how to submit attestations of compliance beginning in 2022.

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