2021 Consolidated Appropriations Act (CAA)

No Surprises Act - Key Health Plan Provisions

No Surprises Act

What Employers Need to Know

The Consolidated Appropriations Act (CAA), signed into law on December 27, 2020, includes many benefit and tax provisions affecting employers and group health plan sponsors.

The No Surprises Act, also included in the CAA, is federal legislation aimed at protecting health plan participants from surprise medical bills, which can occur when patients unexpectedly receive care from out-of-network (OON) providers. For example, a patient may go to an in-network (INN) hospital for emergency care or surgery, but an OON doctor may be involved in the patient's care, triggering unexpected costs. Patients often cannot determine the network status of these providers prior to treatment to avoid these additional charges, and they are rarely involved in the choice of provider at all.

The provisions of this Act are intended to reduce these unexpected costs and increase patient awareness of costs and provider network status.

Applies To: Non-Grandfathered and Grandfathered Group Health Plans (GHP); Fully-Insured (FI) and Self-Funded (SF) GHP; Large and Small Employer GHP; and Private, Government and Non-Profit Employer GHP

Does Not Apply To: HRAs; Excepted Benefits; or Retiree-Only Plans

No Surprises Act	Effective Date	Questions to Discuss with Carrier/TPA
Surprise Medical Billing	Plan Years beginning on/after 1/1/2022	• Have the plan documents and summary plan description been updated to include the Surprise Medical Billing provisions? • Does the TPA agreement for self-funded plans address Surprise Medical Billing requirements, including quick payment/denial provisions, payment of arbitration costs and reporting for air ambulance services, and what cost impact will these provisions have on the plan?
Accurate Provider Directories	Plan Years beginning on/after 1/1/2022	• What internal audit procedures are in place to ensure provider directories are being kept up-to-date, and does the agreement indemnify the health plan against costs incurred due to errors in the directory?
Enhanced Health Plan ID Cards	Plan Years beginning on/after 1/1/2022	• Will participant ID cards include required information, including INN/OON deductibles, OOP maximum and a telephone number/website address for assistance?
Continuity of Care	Plan Years beginning on/after 1/1/2022	• Have the plan documents and summary plan description been updated to include the Continuity of Care provisions; how will Continuity of Care be communicated to impacted participants; and what cost impact will it have on the plan?
Price Comparison Tool	Plan Years beginning on/after 1/1/2023	• What tools are currently in place to allow participants to compare costs for services and their cost-sharing responsibility; what enhancements will be needed to comply with these requirements; and at what cost to the Carrier/TPA and to the plan? • Does the TPA agreement for self-funded plans address who will be responsible for errors within the tool, and what disclaimer language will be included?
Advance Explanation of Benefits (EOB)	Delayed Enforcement Pending Guidance	• What steps are being taken to comply with the Advanced EOB requirements and when will the carrier/TPA be in compliance? • Has the TPA agreement for self-funded plans been updated to address Advanced EOBs and does it specify who is responsible for penalties for non-compliance (or costs for providing incorrect information)?
CAA Transparency	**Effective Date**	**Questions to Discuss with Carrier/TPA**
Reporting on Pharmacy Benefits and Rx Costs	2020 data due 12/27/21; however, Departments will not initiate enforcement action if 2020 and 2021 data is submitted by 12/27/22	• What information is currently available for reporting; what enhancements will be needed to comply with annual reporting requirements; and when will the carrier/TPA be in compliance? • Has the TPA/PBM agreement been revised to include this reporting service?

No Surprises Act – Key Provisions for Plan Sponsors

Surprise Billing

PY Beginning On/After 1/1/22

Plans must limit cost-sharing to INN amounts (and providers may not balance bill) for:

- OON emergency care;
- Ancillary services provided by certain OON providers at INN facilities; and
- OON air ambulance services

Must follow specific process to negotiate reimbursement rate and/or submit for independent dispute resolution (IDR)

Provider Directories

PY Beginning On/After 1/1/22

INN Provider Directories must be:

- Up-to-date; and
- Accessible online and by phone (phone verifications followed-up in writing or electronically within one business day)

Participants relying on inaccurate data are only responsible for INN cost-sharing

Continuity of Care

PY Beginning On/After 1/1/22

When a provider is removed from a plan's network, plans must notify certain "continuing care" patients of the removal and, if elected, cover services by the provider under the same terms and conditions for up to 90 days following notice

Health Plan ID Cards

PY Beginning On/After 1/1/22

Health Plan ID cards must disclose:

- INN and OON Deductibles;
- OOP Maximum; and
- Telephone number and website address for assistance

Advance EOB

Enforcement Delayed

Plans must provide advance EOB upon request and before scheduled care, including:

- Whether provider is INN or OON;
- Good faith estimate of cost received from provider based on billing and diagnostic codes;
- Good faith estimate of cost-sharing amount enrollee must pay (with YTD totals paid toward deductibles and OOP) + amount plan will pay

Tool for Price Comparison

PY Beginning On/After 1/1/23

Plans must offer price comparison guidance via telephone and through a plan website, enabling participants to compare the amount of cost-sharing they would be responsible for paying for specific items and services, based on PY, geographic region and provider status (INN/OON)

INN = In-Network OON = Out-of-Network OOP = Out-of-Pocket PY= Plan Year FI = Fully Insured SF = Self-Funded

Required Notice

PY Beginning On/After 1/1/22

Group health plans must provide information to participants describing state/federal surprise billing protections and providing contact information where complaints can be filed. This information must be made publically available, posted on a public website of the plan or issuer and included with EOB's for OON claims. A model notice is available, and required federal agency contact information and website URL can be found in this CMS Memo.

Annual Reporting on Pharmacy Benefits and Rx Costs

12/27/21 with Deferred Enforcement to 12/27/22

The CAA also includes additional transparency requirements, including annual reporting on pharmacy benefits and Rx costs. GHP and issuers must report to HHS, DOL and IRS the following:

- Plan Year dates, number of enrollees, and each state where coverage is provided;
- 50 brand Rx most frequently dispensed and total number of paid claims paid for each;
- 50 most costly Rx by total annual spending and amount spent for each;
- 50 drugs with greatest expenditure increase over previous plan year and change in amounts;
- Total spending on health services by (i) cost type; (ii) average monthly premium paid by employers and enrollees; and (iii) premium impact of rebates, fees and other remuneration

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