Consolidated Appropriations Act: Group Health Plan Checklist

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Requirement and Initial Effective Date (Note: Some Effective Dates Now Delayed)	Description	Action Steps
Removal of Gag Clauses **Effective Immediately**	Plans cannot enter into agreements which restrict the disclosure of certain information relating to cost and quality. Annual attestation will be required.	• Review existing contracts to include specific language reflecting the change • Monitor for future guidance on how to submit attestation
Mental Health Parity and Addiction Equity Act (MHPAEA) Comparative Analysis **February 10, 2021**	Plans must prepare, and provide to certain entities upon request, a written analysis of how the plan complies with MHPAEA's rules on nonquantitative treatment limitations (NQTLs). Must be provided to certain entities, such as Department of Labor (DOL), Health and Human Services (HHS), or certain state agencies.	• Work with vendors to prepare analysis • For employers with self-funded, nonfederal governmental plans, consider whether to "opt out" of MHPAEA requirements
Broker and Consultant Compensation Disclosure **December 27, 2021**	Brokers and consultants must disclose certain compensation they receive. Disclosure generally applies if amount exceeds $1,000. No clarification yet on exact scope of entities covered.	• Perhaps begin analyzing contracts, although lack of guidance makes analysis a bit difficult at this point

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Medical and Drug Cost Reporting **December 27, 2021 (Now Delayed, Likely Until December 27, 2022 per ACA FAQs Part 49)**	Plans must report certain information to the federal government related to prescription drugs. Report will be periodic and ongoing. No clarification yet on details of reporting process.	• Discuss with vendors if they will be conducting the reporting. If so, verify cost and contractual terms. Reflect same in contractual amendment. • Note that lack of guidance may result in vendors being uncertain about whether they will conduct reporting and, if so, cost to plan sponsor.
Surprise Billing **Plan years beginning on or after January 1, 2022**	**Emergency Services Provided by a Nonparticipating Provider/Facility:** Plans generally must cover emergency services provided by a nonparticipating provider/facility without prior authorization and at in-network rates. Enrollees generally receive protection against balance billing from the provider. **Non-emergency Services Provided by Nonparticipating Providers at Participating Facilities:** Plans generally must cover non-emergency services provided by a nonparticipating provider at a participating facility at an in-network rate. **Independent Dispute Resolution ("IDR") Process:** If provider objects to payment level, expectation is that plan and provider will initially negotiate the amount. If there is still no agreement, either may request an IDR process to apply. IDR process generally will result in a binding decision on amount plan must pay.	• Work with vendors to ensure that they are complying with rules on behalf of plan sponsor. o Update vendor contract to reflect same and cost (e.g., whether plan sponsor will pay for IDR costs) • IDR regulations from October 2021 also provide for certain expansions of external review process related to these payments. These are essentially new "rights" for plan enrollees. So, plan sponsor should update plan document / SPD for new requirements.

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Surprise Air Ambulance Bills **Plan years beginning on or after January 1, 2022**	Air ambulance bills now subject to similar rules as in section immediately above. Intent is to protect plan enrollees for what can be large air ambulance bills.	Similar to above action items
Reporting Requirements Regarding Air Ambulance Services **90 days after the last day of the first calendar year beginning on or after the date final rules are issued**	Plan sponsor / plan must report certain, detailed air ambulance information to the federal government.	• Verify if vendors (e.g., TPA) will conduct such reporting. Modify contract to reflect new services.
Modify Identification Cards **Plan years beginning on or after January 1, 2022**	Identification cards now must include additional information relating to deductibles, out-of-pocket maximums ("OOPM").	• Verify if vendor (e.g., TPA) will update cards and cost for doing so. Modify contract to reflect new services.
No Discrimination Against Certain Providers January 1, 2022	The Affordable Care Act contained a somewhat-unclear provision stating that plans cannot discriminate against providers acting within the scope of their license or certification. Scope of rule unclear under ACA. Future CAA guidance should clarify what is required.	• Monitor for clarifications. If necessary, modify plan provisions which could be impacted (e.g., possible that limitations on coverage of midwife services might need to be removed).

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Advanced Explanation of Benefits ("EOB") **Plan years beginning on or after January 1, 2022 (now delayed)**	Plans must provide participants, upon request, with an advanced EOB for certain services. Will require plan (e.g., TPA on behalf of plan) to coordinate with provider on expected procedures.	• Confirm in writing that TPA (insurer, if plan is fully-insured) will comply with rules and if so, cost. Update contract to reflect same. • Once details are known of what new rights enrollees have, modify plan document / SPD to describe same.
Continuity of Care **Plan years beginning on or after January 1, 2022**	Plans must continue to cover certain benefits on an in-network basis when a provider or facility ceases to be in-network. Will require COBRA-like provisions, with plan notifying enrollee of right to obtain this benefit and enrollee electing the benefit. Generally applies for serious and complex (or terminal) medical conditions.	• Confirm that TPA will administer changes. Modify contract to reflect same. • Amend plan documents and SPDs once details are known (no guidance yet)
Price Comparison Tool **Plan years beginning on or after January 1, 2022 (now delayed)**	Plans must offer price comparison guidance by phone and a price comparison tool online. Goal is that enrollees will be able to compare costs of various providers. Note that rule, per federal agencies own statements, overlaps with November 2020 "Transparency Regulations." Expect future guidance to harmonize the two.	• Monitor for future developments.

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Provider Directory and Coverage Information Requests **Plan years beginning on or after January 1, 2022**	Plans must create a database on a public website that includes a list of providers and facilities that are in-network. Information must be verified and updated every 90 days (e.g., to remove providers who have left network). If information that plans provide about in-network status is incorrect, plan enrollee may be protected from higher cost-sharing amounts.	• Confirm that vendor will comply with rules. Update contract with vendor. • Most difficult issue in contract may be allocating risk of incorrect information. Will TPA be responsible if incorrect information is provided to plan enrollee?

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