



Highlights and Resources – Consolidated Appropriations Act 2021

Transparency in Coverage & No Surprise Act Provisions

CAA Provision	Overview & Resources
Mental Health Parity & Addition Equity Act (MHPAEA)	Under the MHPAEA, self-funded (over 50 employees only) and fully insured group health plans that cover mental health conditions and substance use disorders (MH/SUD) must provide those benefits at the same level as medical and surgical (M/S) benefits. The Affordable Care Act (ACA) expanded on MHPAEA by including MH/SUD benefits as one of the 10 essential health benefits (EHBs) that all individual and small-group health insurance plans must cover and requiring parity compliance. CAA amended MHPAEA, in part, by expressly requiring group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical benefits and MH/SUD benefits and that impose NQTLs on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs. Plans must perform and document comparative analysis of design and application of non-quantitative treatment limits (NQTLs). The analysis must be made available to state and federal authorities upon request.
Advanced EOBs	Impacts self-insured and fully insured group At the request of the member and on notice from providers that have a member scheduled service, plan must provide written “good faith” cost estimates for proposed services
Insurance Cards	Insurance ID Cards must include deductibles, (IN and OON), out of pocket maximum amounts, phone number and website for member assistance. (In addition to any state requirements)
Broker & Agent Compensation Disclosure	Agents, brokers, and consultants (“covered service providers”) must disclose actual and anticipated cash and non-cash compensation they expect to earn in connection with the sale, renewal, and extension of group health insurance. Covered service providers must also include a description of the services they will provide under the arrangement as part of the disclosure
Provider Directories & Price Comparison Tools	Plans are required to maintain a listing of network providers and certain data on each provider. The data must be updated at least every 90 days. Requires plans to provide members with cost sharing information for a particular service provided by an in-network provider
No Surprise Billing	Protects members in a group and individual health plans from receiving surprise medical bills or “balance billing” when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. It also establishes an independent dispute resolution process for payment disputes between plans and providers, and provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they get from the provider. – Employers must also disclose these rights using CMS Model No Surprise Billing Notice.
Pharmacy Benefit & Health Cost Information Reporting (RxDC and MRFs)	RxDC Reporting: All employer group health plans regardless of size and funding types are required to report plan information and high level Rx utilization metrics to include spending data, top drugs in specific categories, rebates, and impact on rebates on plan costs on CMS HIOS Data Collection Portal. May involve all vendors and employer to complete the annually required reporting DUE BY JUNE 1st of each year for previous calendar year. Health Cost Data Reporting (MRF): Plans and issuers are required to publicly display in-network provider negotiated rates, historical out-of-network and allowed amounts through Machine-Readable Files (MRFs) on an internet website. Note: most insurance carriers have agreed to take on this responsibility for clients and house the files on their own public sites on behalf of clients. Sample from UHC: https://transparency-in-coverage.uhc.com/
Gag Clause Prohibition Attestation	NEW - ALL Health Insurers & Group Health Plan Sponsors are required to submit through CMS their attestation that there are no “gag clauses”, agreements, or contractual language with any health care provider, network, association of providers, and TPAs that would directly or indirectly restrict a plan or issuer from detailed information regarding pricing, quality of care, financials, detailed claims data, service codes, provider information for plan administrators, business associates, and participants consistent with applicable privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA. DUE BY DECEMBER 31 annually.

[Consolidated Appropriations Act, 2021 \(CAA\) | CMS](#)