CONSOLIDATED APPROPRIATIONS ACT, 2021
No surprises act, 2022, and
Transparency in coverage rule summary

For Plan Years Beginning on or After January 1, 2022

Continuing Care Patient

- Allows certain members who are continuing care patients to elect, if their provider/facility loses PPO network status, to continue receiving in-network benefits for the care from that provider/facility.

  A Continuing Care Patient is defined as someone who is:

  - undergoing a course of treatment from a provider or facility for a serious and complex condition;
  - undergoing a course of institutional or inpatient care;
  - scheduled to undergo nonelective surgery;
  - pregnant and undergoing a course of treatment for the pregnancy; or terminally ill.

Electronic Provider Database

- Must provide access to PPO network provider database on plan's website.

  Note: *Electronic provider information is now available through networks directly. Links to available PPO networks are located on our website. PPO networks are responsible for the accuracy and maintenance of their databases and directories.*

ID Card Updates

- Must provide clear information on deductibles and out-of-pocket limits, along with a telephone number and website address for consumer assistance on ID cards.

  Note: *Members of health benefit plans administered by E.D.I.S., will receive an updated ID card showing the out-of-pocket maximum at the start of their new plan year beginning on or after 1/1/22.*

Independent Dispute Resolution * *Note, court challenges in March 2022 are changing provisions of this mandate*

- A federal process has been established to resolve disputes regarding plan out-of-network payments for emergency services provided by nonparticipating providers/facilities/air ambulances and for non-emergency services furnished by certain nonparticipating providers/facilities at participating healthcare facilities. Process deadlines provided at www.employerdriven.com/compliance.

Non-Emergency Care at an In-Network Facility Utilizing an Out-Of-Network Provider

- Unless notice and consent (see below) is satisfied[4], a member's cost share for non-emergency care at an in-network facility by an out-of-network healthcare provider will be calculated using the lesser of: the billed amount or the median of the applicable contracted rates. The cost-share amount will be applied to the in-network deductible and in-network out-of-pocket limit. Ultimate payments by the plan may be subject to independent dispute resolution.

Notice and Consent

- Most out-of-network providers[4] must notify a member that they are not in the patient's PPO network and obtain the patient's written consent before providing non-emergency care.

Out-Of-Network Emergency Care

- Cost share for out-of-network emergency care will be calculated using the lesser of: the billed amount or the median of the applicable contracted rates. The cost-share amount will be applied to the in-network deductible and in-network out-of-pocket limit. Ultimate payments by the plan may be subject to independent dispute resolution.

Plan Document Updates

- Must be revised with language to meet requirements

- Note: Members of a health benefit plan administered by E.D.I.S., will receive an updated plan document at the start of their new plan year beginning on or after 1/1/22.

Prohibition of Balance Billing

- Out-of-network providers are prohibited from balance billing for certain types of services:
    - Out-of-network emergency care
    - Certain types of care by an out-of-network provider at an in-network facility
    - Out-of-network air ambulance services

- Note: This provision only applies to our major medical plan designs with a PPO network.

Prohibition of Prior Authorization for Emergency Care

- Prior authorization cannot be applied to emergency care provided by emergency departments and freestanding emergency-care facilities.

- Note: We already support compliance with this provision: Our plan designs do not require prior authorization for emergency care.

Prohibition of Surprise Air Ambulance Bills

- If a member is transported by an out-of-network air ambulance, cost sharing must be calculated using the lesser of: the billed amount or the median of the applicable contracted rates. The cost-share amount will be applied to the in-network deductible and in-network out-of-pocket maximum. Ultimate payments by the plan may be subject to independent dispute resolution.

Effective July 1, 2022

Transparency in Coverage Rule: Machine Readable Files

- Must provide in-network negotiated rates, and out-of-network allowed amounts and billed charges on a public website.

Effective January 1, 2023

Transparency Tool: Price Comparison Tool

- **Effective for plan years beginning on or after 1/1/23,** the No Surprises Act requires the provision of a tool to estimate cost-sharing information that members can access, via the Internet and by telephone, for a specific healthcare service among participating providers in a particular geographic region during the plan year.

  The Transparency in Coverage Rule requires a web tool (available to members) making certain information available for:

  - 500 items and services identified by the federal government, **effective for plan years beginning on or after 1/1/23**
  - all other items and services, **effective for plan years beginning on or after 1/1/24**

Provisions Delayed Pending Federal Guidance

Advance EOBs

Good-faith Estimate

Prescription Drug Machine Readable Files

Reporting of Spend on Drug and Healthcare Services, and Premium Paid

[1] The Consolidated Appropriations Act, 2021 was signed into law on Dec. 27, 2020.
[2]The No Surprises Act is part of the Consolidated Appropriations Act, 2021. The No Surprises Act does not apply to health reimbursement arrangements (HRAs) or other account-based group health plans, short-term, limited-duration insurance, and retiree-only plans.
[3] The Transparency in Coverage rule was released on Oct. 29, 2020, by the U.S. Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. The rule does not apply to health reimbursement arrangements (HRAs) or other account-based group health plans, short-term, limited-duration insurance, grandfathered plans, and retiree-only plans.
[4] The following providers cannot provide notice and consent and their services are subject to the No Surprises Act: radiologists, anesthesiologists, pathologists, neonatologists, assistant surgeons, hospitalists and intensivists. In the case of an emergency, notice may be provided after a patient is stabilized. If notice and consent is not issued/obtained, protections of the No Surprises Act continue to apply.