**Consolidated Appropriations Act: Employee Benefits Provisions Summary**

**No Surprises Act**

Effective January 1, 2022. Protects against balance-billing and out-of-network cost sharing for ER services, non-emergency services by out-of-network providers at in-network facilities, and out-of-network air ambulance providers. Examples includes anesthesia, ER physicians, ambulance.

**REMOVAL OF GAG CLAUSES**

Effective January 1, 2022. Employer health plans cannot enter into agreements restricting the disclosure of certain information relating to cost and quality. Plans must submit to an annual “attestation” to show they are compliant with the requirements.

**BROKER AND CONSULTANT COMPENSATION DISCLOSURE**

Effective December 27, 2021. Brokers and consultants must disclose certain compensation they receive for consulting and brokerage services if the amount exceeds $1,000. They must also disclose indirect compensation such as commissions. If there is an error within the disclosure, they must correct it within 30 days. ERISA violation if not completed.

**Prescription Drug- COST REPORTING**

Effective December 27, 2022 per HHS (Previously Effective December 27, 2021.) Employer health plans must submit claims and pricing information to the Federal Government (CMS, HHS and DOL) annually. Data sets include, nut not limited to: Top 50 meds by cost, utilization, by branded and specialty distinction, premiums, etc… Info is reported on a calendar year basis. 1st reporting includes 2020 and 2021 reporting periods. 2022 is due June 1st, 2023 and then June ongoing annually.

**MACHINE READABLE FILES**

Effective July 1, 2022. Insurers and health plans must publicly post specific machine-readable files. Files must include items including, but not limited to: negotiated rates, underlying fee schedules, billed amts vs allowed amts, and historical pricing for prescription drugs. These are not member-friendly tools, but will phase into more member-friendly access in 2023 and 2024.

**MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) COMPARATIVE ANALYSIS**

Effective February 10, 2021. Employer health plans must prepare and provide a written analysis of how the plan complies with [MHPAEA’s rules](https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/appropriations-act-requires-employer-actions-to-ensure-mental-health-parity.aspx) on [nonquantitative treatment limitations](https://ogletree.com/insights/new-mental-health-parity-guidance-and-enforcement-efforts-may-warrant-a-deep-dive-into-plan-administration/) (NQTLs) upon request. This includes entities such as Department of Labor (DOL), Health and Human Services (HHS), or certain state agencies.

**SURPRISE BILLING**

Effective January 1, 2022. Employer health plans must cover emergency services provided by a non-participating provider/facility without prior authorization and at in-network rates. Patients will generally receive protection against balance billing from the provider. Additionally, health plans must cover non-emergency services provided by a non-participating provider at a participating facility at an in-network rate. If the provider objects to payment level, the plan and provider will initially negotiate the amount. If there is still no agreement, either may request an Independent Dispute Resolution (“IDR”) process. IDR process generally will result in a binding decision on an amount the plan must pay.

**SURPRISE AIR AMBULANCE BILLS**

Effective January 1, 2022. Air ambulance bills will be subject to similar rules as the Surprise Billing section above. The intent is to protect plan enrollees for what can be significant air ambulance bills.

**MODIFY IDENTIFICATION CARDS**

Effective January 1, 2022. Identification cards now must include additional information relating to deductibles and out-of-pocket maximums; including Out-Of-Network benefits.

**ADVANCED EXPLANATION OF BENEFITS (“EOB”)**

Delayed. Previously Effective January 1, 2022. Employer health plans must provide patients with an advanced EOB for certain services upon request. This will require plans (or the TPA on behalf of the plan) to coordinate with the provider on expected procedures.

**CONTINUITY OF CARE**

Effective January 1, 2022. Employer health 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 applicable for serious and complex (or terminal) medical conditions.

**PRICE COMPARISON TOOL**

Effective January 1, 2022 with 2nd & 3rd stages coming in 2023 and 2024. Employer health plans must offer price comparison guidance by phone and a price comparison tool online. The goal is that patients will be able to compare costs for various providers.

**PROVIDER DIRECTORY AND COVERAGE INFORMATION REQUESTS**

Effective January 1, 2022. Employer health 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 (to remove providers who have left network.) If information that plans provide about in-network status is incorrect, the plan enrollee may be protected from higher cost-sharing amounts.