2021 CONSOLIDATED APPROPRIATIONS ACT COMPLIANCE CHECKLIST FOR PLAN SPONSORS

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(Updated as of October 2023)

Caution: *This checklist provides a summary of the principal requirements under the 2021 Consolidated Appropriations Act (CAA) that apply to employer-sponsored group health plans. Employers should always review the CAA and its related applicable guidance when analyzing how these requirements apply to any plan.*

Requirement/ Effective Date	***Description***	***Type of Plan***[1]	***Plan Sponsor Action Items to Consider***
	CAA Changes in 2020		
Employer Student Loan Payments **Effective Immediately**	The Coronavirus Aid, Relief, and Economic Security Act permitted employers to amend their Code Section 127 educational assistance plans to allow for tax-free employer payments of principal and interest on qualified education loans incurred by employees. This optional relief originally was available only for certain payments in 2020 but is now available through December 31, 2025.	Code Section 127 Educational Assistance Plans	• Consider offering or amending a Code Section 127 educational assistance plan to take advantage of this extension.
Removal of Gag Clauses **Effective Immediately**	Plans cannot enter into agreements that directly or indirectly restrict them from: (1) providing cost or quality of care information to referring providers, plan sponsors, participants, or individuals eligible to become participants; (2) accessing deidentified claims and encounter information with respect to participants; and (3) sharing information described in (1) or (2) with a HIPAA business associate. Nonetheless, such agreements may include reasonable restrictions on public disclosure. Plans must submit a Gag Clause Prohibition Compliance Attestation annually on the Health Insurance Oversight System	Group Health Plans (Including Grandfathered Health Plans)	• Review agreements between the plan and health care providers, provider network/associations, TPAs, and/or service providers offering access to a network of providers to confirm that they do not have gag clauses. And, if necessary, amend agreements to remove any gag clauses. • Confirm in writing whether TPAs (or insurance companies for insured

[1] The CAA clarifies that PHSA Sections 2799A-1 (Section 102 related to surprise medical billing for emergency services and nonparticipating providers at participating facilities, Section 103 related to the Independent Dispute Resolution process for emergency services and nonparticipating providers at participating facilities, Section 107 related to identification cards with deductibles and out-of-pocket maximum information, Section 111 related to advanced explanation of benefits), 2799A-2 (Section 105 related to surprise air ambulance bills), and 2799A-7 (Section 102 related to other patient protections) apply to grandfathered health plans for plan years beginning on or after January 1, 2022.

In FAQs About ACA and CAA Implementation Part 49, Q/A-11, the Departments indicated that grandfathered health plans are generally subject to the requirements under the CAA. Additionally, the CAA amended ACA to clarify that the new and recodified patient protection provisions of division BB of the CAA, including those related to choice of health care professional, apply to grandfathered health plans.

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	("HIOS"). The first attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020 through the date of attestation. Subsequent attestations, covering the period since the last preceding attestation, are due by December 31 of each year thereafter.		plans) will comply with these rules. • If applicable, review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement. • If TPA will not submit the attestation, authorize an appropriate individual within the organization (e.g., the plan administrator) to attest on behalf of the plan.
	CAA Changes in 2021		
Mental Health Parity and Addiction Equity Act (MHPAEA) Comparative Analysis **February 10, 2021**	Plans that offer medical and surgical benefits and mental health or substance use disorder benefits and impose nonquantitative treatment limitations (NQTLs) on the mental health or substance use disorder benefits must be able to provide a detailed comparative analysis regarding compliance with the MHPAEA's NQTL rule upon request from the Department of Labor (DOL), Health and Human Services (HHS), or applicable state agency.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. If the TPA cannot assist, consider possible vendors to hire for this purpose. • Consider conducting an internal audit to ensure compliance with MHPAEA.
Broker and Consultant Compensation Disclosure **December 27, 2021**	Brokers and consultants must disclose compensation and describe services rendered to plans pursuant to Section 408(b)(2) of ERISA. The disclosure must be made in writing to the plan fiduciary if direct or indirect compensation for services is expected to exceed $1,000. This disclosure requirement applies before a contract is entered into, extended, or renewed. A special notice rule applies for changes to the fees or services.	Group Health Plans (Including Grandfathered Health Plans)	• Analyze the status of all broker and consultant contracts and determine when such contracts must be extended or renewed. • When a plan enters into, extends, or renews broker and/or consultant contracts, ensure such brokers and consultants provide timely and

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			complete compensation disclosures. • Use the compensation disclosures when selecting and monitoring service providers.
Medical and Drug Cost Reporting **December 27, 2021**	Plans must report certain information related to plan medical costs and prescription drug spending to DOL, HHS, and Treasury. The first report is due on December 27, 2021 (subsequently delayed to December 27, 2022 with a January 31, 2023 grace period) and subsequent reports are due no later than June 1 of every subsequent year. Eighteen months after December 27, 2021, DOL, HHS, and Treasury will post a report on their respective websites on prescription drug reimbursements, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this reporting requirement. • Use the report posted on DOL, HHS, and Treasury websites as a comparison tool to review and revise current plan medical spending and drug costs and as a reference point for future requests for proposal.
CAA Changes in 2022			
Surprise Billing and Independent Dispute Resolution (IDR) **Plan years beginning on or after January 1, 2022**	**Emergency Services Provided by a Nonparticipating Provider/Facility:** If a plan covers emergency services in an emergency department, a plan must cover emergency services provided by a nonparticipating provider/facility without prior authorization and with in-network cost-sharing. The plan must apply cost-sharing towards the participant's deductible and out-of-pocket maximum (OOPM). Neither the nonparticipating facility nor the nonparticipating provider can balance bill the participant. **Non-emergency Services Provided by Nonparticipating Providers at Participating Facilities:** The plan must cover non-	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to delineate responsibilities regarding surprise billing, timely payments/denials,

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	emergency services provided by a nonparticipating provider at a participating facility with in-network cost-sharing. The plan must apply cost-sharing towards the participant's deductible and OOPM. The non-participating provider cannot balance bill the participant unless the non-participating provider provides notice and the individual consents. This notice and consent exception does not apply if the provider is an ancillary provider (e.g., anesthesiologist), there is no participating provider available at the participating facility, or the care is for unforeseen or urgent services. The plan must make an initial payment or notice of denial within 30 days after the nonparticipating provider/facility transmits a bill for services. The plan and the nonparticipating provider/facility may engage in open negotiations for 30 days regarding the nonparticipating claim. If negotiations fail, the plan or nonparticipating provider/facility may request IDR. The losing party must pay the entire cost of the IDR. Insured plans may be subject to state surprise billing laws instead of IDR.		negotiations, and arbitration. o Consider adding language regarding who makes decisions (e.g., the TPA/insurance company, the plan, or both). o Consider adding language regarding notification requirements (e.g., if the plan receives a claim from a nonparticipating provider/facility, the TPA will notify the plan prior to paying/denying the claim). o Consider adding language about who pays for IDR. • Amend plan documents and SPDs as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of potentially increased plan costs.
Surprise Air Ambulance Bills **Plan years beginning on or after January 1, 2022**	If the plan covers air ambulance services from participating providers, the plan must cover air ambulance services from a nonparticipating provider with in-network cost-sharing. The plan must apply cost-sharing towards the participant's deductible and OOPM. The air ambulance nonparticipating provider cannot balance bill the participant. The plan must make an initial payment or notice of denial within 30 days after the air ambulance nonparticipating provider transmits a bill for services. The plan and air ambulance nonparticipating provider may engage in open negotiations for 30 days regarding the air ambulance claim.	Group Health Plans (Including Grandfathered Health Plans)	*See above action items for Surprise Billing.*

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	If negotiations fail, the plan or the nonparticipating air ambulance provider may request IDR. The losing party must pay the entire cost of the IDR.		
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**	Plans must provide detailed reports to DOL, HHS, and Treasury, as applicable, regarding air ambulance claims.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this reporting requirement.
External Review for Surprise Billing **January 1, 2022**	Plans must expand their external review process to include adverse benefit determinations for the surprise bills and surprise air ambulance bills.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Amend plan documents and SPDs as necessary.
Choice of Health Care Professional **January 1, 2022**	Although this requirement already applied to non-grandfathered health plans, if a plan requires a participant to designate a primary care provider, grandfathered health plans must allow participants to choose any participating primary care provider, including pediatricians, and access OB/GYN care without the need for prior authorization or a referral. Plans must include a notice of these patient protections whenever a summary plan description or other similar description of plan benefits is provided to a participant or beneficiary.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Amend plan documents and SPDs as necessary.
Identification Cards with Deductibles and Out-of-Pocket Limit	Plans must include information regarding deductibles, OOPM, and a phone number/website for consumer assistance on their physical and electronic insurance identification cards for participants.	Group Health Plans (Including	• Confirm in writing that TPAs (or insurance companies for insured plans) that provide ID cards will

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Information **Plan years beginning on or after January 1, 2022**		Grandfathered Health Plans)	comply with these rules and discuss any associated cost increases. • Request a sample ID card and confirm compliance. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement.
Protections Against Provider Discrimination **January 1, 2022**	Under the Affordable Care Act, plans must not discriminate with respect to plan participation or coverage against any health care provider acting within the scope of the provider's license or certification. DOL, HHS, and Treasury must issue proposed regulations implementing this requirement by January 1, 2022, and issue final regulations six months after the comment period.	Group Health Plans	• Comply with guidance, once issued, regarding protections against provider discrimination.
Enforcement Deferred[2] **Advanced Explanation of Benefits** **Plan years beginning on or after January 1, 2022**	Plans must provide participants, upon request, with an advanced EOB for scheduled services that generally explains the estimated costs for the item or service and the applicable cost-sharing requirements.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement. • Amend plan documents and SPDs as necessary.

[2] Pursuant to FAQs About ACA and CAA Implementation Part 49, the Departments deferred enforcement of the requirement that plans and issuers provide an advanced EOB until: (1) the Departments have established standards for the data transfer between providers/facilities and plans/issuers; and (2) providers/facilities and plans/issuers have enough time to build the infrastructure necessary to support the data transfers.

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Continuity of Care **Plan years beginning on or after January 1, 2022**	Plans must take various actions if participants who are "continuing care patients" lose their benefits with respect to a participating provider/facility because the plan's contractual relationship with the provider/facility terminates or benefits with respect to the provider/facility terminate. These actions include: (1) notifying the continuing care patient about the termination and the participant's right to transitional care; (2) providing the continuing care patient with an opportunity to notify the plan of their need for transitional care; and (3) allowing the continuing care patient to elect to continue to have benefits under the plan on the same terms and conditions as if the termination had not occurred for 90 days (or, if earlier, the date the participant is no longer a continuing care patient). A "continuing care patient" is an individual who, with respect to a provider/facility, is scheduled for nonelective surgery or is undergoing treatment for a serious and complex condition, a pregnancy, or a terminal illness.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss associated cost increases. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement. • Amend plan documents and SPDs as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of potentially increased plan costs.
Enforcement Deferred[3] **Price Comparison Tool** **Plan years beginning on or after January 1, 2022**	Plans must make available a price comparison tool by internet website and telephone so participants can compare cost-sharing amounts for specific items and services furnished by a provider.[4]	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. TPAs (or insurance companies) may need to update any existing price comparison tools that they offer.

[3] Pursuant to FAQs About ACA and CAA Implementation Part 49, the Departments intend to propose rules and seek public comments on this requirement and deferred enforcement until plan years beginning on or after January 1, 2023 to align with the Transparency in Coverage Final Rules.

[4] This requirement is in addition to the Transparency in Coverage regulations published in the Federal Register on November 12, 2020 and available here. The Transparency in Coverage regulations generally require plans to make available: (1) personalized out-of-pocket maximum cost information and information about negotiated rates for covered items and services for plan years that begin on or after January 1, 2023; and (2) three files regarding negotiated rates for covered items and services from in-network providers, historical payments to out-of-network providers, and in-network negotiated rates and historical prices for covered prescription drugs, to the public starting with plan years beginning on or after January 1, 2022. Pursuant to FAQs About ACA and CAA Implementation Part 49, the Departments temporarily deferred enforcement of the requirement that plans and issuers publish machine-readable files related to prescription drugs. However, in FAQs About ACA Implementation Part 61, published on September 27, 2023, the Departments rescinded the enforcement relief for the machine-readable files related to prescription drugs and indicated they will enforce the requirement on a case-by-case basis. The Departments also deferred enforcement of the requirement that plans and issuers publish machine-readable files for in-network rates and out-of-network allowed amounts and billed charges until July 1, 2022 for plan years beginning on or after January 1, 2022.

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			• Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify responsibilities regarding this requirement.
Provider Directory and Coverage Information Requests **Plan years beginning on or after January 1, 2022**	Plans must establish a database on a public website that includes a list of providers and facilities that have a direct or indirect contractual relationship with the plan and directory information. Plans must verify and update the database at least every 90 days and remove any providers or facilities if the plan cannot verify their information. Plans must also include information on print directories that the directory was accurate as of the date of publication and that the participant should consult the plan's database to obtain the most current information. Plans must establish a response protocol for responding within one business day to a participant who requests information regarding whether a provider or facility is in-network and also save the communication in the participant's file for at least two years. Plans must impose in-network cost-sharing and apply the deductible or OOPM to an item or service provided by a nonparticipating provider or nonparticipating facility if the plan's database, directory, or response protocol incorrectly indicated that the item or service was in-network. Plans must make publicly available, post on a public website, and include on each EOB, information regarding prohibitions on balance billing in certain circumstances and, if applicable, additional information required under state law. Model notice is available here.	Group Health Plans (Including Grandfathered Health Plans)	• Confirm in writing that TPAs (or insurance companies for insured plans) will comply with these rules and discuss any associated cost increases. TPAs (or insurance companies) may need to update any existing online databases that they offer. • Review and revise service contracts with TPAs (or insurance contracts for insured plans) to clarify who will maintain the online database, revise any print directories, respond to participant requests for information, and provide disclosures regarding protections against balance billing. • Amend plan documents and SPDs as necessary. • For self-funded plans, consider whether to reevaluate stop-loss arrangements because of potentially increased plan costs.

Note: This summary is intended to provide general information. It should not be relied on as legal advice or as a legal opinion on any specific facts or circumstances. You are urged to consult legal counsel concerning your situation and any specific legal questions you may have.