Russell L. Richeda
Michele R. Stafford
Shaamini A. Babu
Brandie M. Barrows
Ana P. Hallmon
Anne M. Bevington
Allan D. Shuldiner
Sun M. Chang
Matthew P. Minser
Tino X. Do
Jonathan J. Sha
Craig L. Schechter
Sunny S. Shapiro

SALTZMAN & JOHNSON
LAW CORPORATION

1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502
(510) 906-4710
www.sjlawcorp.com

Warren H. Saltzman
(1925-1988)

Richard C. Johnson
(1942-2014)

**Paralegals**

Elise Cotterill
Nargis Shaghasi
Wint Huskey
Alicia Wood

# BULLETIN

**TO:** Health Plan Clients

**CC**: Plan Administrators and Consultants

**DATE:** January 27, 2021

**RE**: Consolidated Appropriation Act 2021

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On December 27, 2020, the President signed the Consolidated Appropriations Act ("Act") which is intended to further respond to the pandemic. The Act also includes provisions impacting health plans from protection from surprise medical bills to ensuring mental health parity and health plan price transparency.

Below is a summary of the current law on health plans as amended by the Act.

## TITLE 1- NO SURPRISES ACT

### Preventing Surprise Medical Bills: Division BB, Title 1, Section 102 (Effective for Plan Years beginning January 1, 2022)

Emergency Services Provided by Out-of-Network Providers

- If a health plan covers emergency services, then the health plan must cover emergency services provided by out-of-network providers: 1) without prior authorization; 2) without regard to whether the provider is a participating provider; and 3) without imposing a greater cost sharing requirement than what would have applied if the services were provided by a participating provider. [1]Any cost sharing payments made by the participant or beneficiary shall be counted toward any in-network deductible or out-of-network maximum under the plan.

- The health plan must either make an initial payment to the out-of-network provider or issue a notice of denial of payment no later than 30 days from transmittal of the bill from the provider and pay a remainder payment equal to the out of network rate. The out of network rate is: 1) amount set by the

[1] This is already required by the Affordable Care Act.

state; 2) amount negotiated with the provider or 3) amount determined by Independent Dispute Resolution. [2]

- The out-of-network provider is prohibited from balancing billing the participant.

Non-Emergency Services Provided by Out-of-Network Providers in In-Network Facilities

- For non-emergency services provided by out-of-network providers in in-network facilities, a health plan cannot impose a greater cost sharing requirement than what would have applied if the services were provided by a participating provider. Any cost sharing payments made by the participant or beneficiary shall be counted toward any in-network deductible or out-of-network maximum under the plan.
- The participant or beneficiary may not be balanced billed unless he or she signed a consent wavier provided by the out-of-network provider 72 hours before the services are scheduled to be delivered. A consent waiver will not apply if: 1) there is no-in-network provider available; 2) the care is unforeseen or urgent; or) is provided by an ancillary provider that a participant normally does not select (i.e.., radiologist, anesthesiologist, pathologist etc.)

- The health plan must either make an initial payment to the out-of-network provider or issue a notice of denial of payment no later than 30 days from transmittal of the bill from the provider and pay a remainder payment equal to the out of network rate. The out of network rate is: 1) amount set by the state; 2) amount negotiated with the provider or 3) amount determined by Independent Dispute Resolution.

Air Ambulance Bills

- If a health plan covers air ambulance services from a participating provider, then the health plan must cover air ambulance services from a non-participating provider. The cost sharing payments required by the participant must be the same as that would apply to a participating provider. Any cost sharing payments made by the participant shall be counted toward any in-network deductible or out-of-network maximum under the plan.

[2] The IDR process is initiated by either the provider or the plan by filing a notice with one of the Secretaries. A certified IDR entity will be selected by the parties to determine the amount of the payment that the plan must pay the out-of-network provider. The decision of the IDR entity is binding on the parties. Both the plan and the provider will submit an offer of payment for the IDR entity to consider. In determining which amount to select the IDR entity may not consider Medicare or Medicaid rates, nor may it consider usual and customary payment rates or the provider's actual billed amount. Instead, it will consider other factors such as the plan's median in-network contracted rate for the item or service in the same insurance market; the provider's level of training, experience, and quality of outcomes; the market share held by the parties; the complexity of providing the services to the participant; whether either party made good faith efforts to enter into an in-network agreement; and other factors relevant to choosing which of the parties' offers is the fairest. The IDR entity must make its decision within 30 days after the dispute is assigned to it. The IDR entity's decision is final and is not subject to judicial review. The plan must make payment to the provider within 30 days of the IDR entity's decision. The cost of the IDR process is paid by the non-prevailing party, unless the parties come to an agreement before the IDR entity issues its decision, in which case the parties will share the cost.

**Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations: Division BB, Title 1, Section 107 (Effective for Plan Years beginning January 1, 2022)**

- A health plan must provide the following information on physical or electronic ID cards: 1) any deductible applicable to plan or coverage; 2) any out-of-pocket maximum applicable to plan or coverage and 3) telephone number and website address through which an individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that the plan has a contractual relationship with for furnishing the services under such plan.

**Consumer Protections Through Health Plan Requirement for Fair and Honest Advance Cost Estimate: Division BB, Title 1, Section 111 (Effective for Plan Years beginning January 1, 2022)**

- A health plan must provide a participant with "Advanced Explanation of Benefits" ("AEOB") prior to scheduled care or upon patient request prior to scheduling. A health plan must send the AEOB either within three days of receiving a request or a notice that a service is scheduled at least 10 business days later, or within one business day of receiving the notice if the service is scheduled within 10 business days of receipt. The AEOB notice must contain the network status of the provider, information on prior authorizations, and estimates of any applicable rates, the participant's expected out-of-pocket expenses, the health plan's expected expenses, and the amounts already incurred towards the participant's out-of-pocket limits.

**Ensuring Continuity of Care: Division BB, Title 1, Section 113 (Effective for Plan Years beginning January 1, 2022)**

- A health plan must ensure that certain participants ("continuing care patient") receive up to 90 days of continued coverage at in-network rates when the participant's provider is no longer an in-network provider. A continuing care patient is an individual who: 1) is undergoing a course of treatment for a serious and complex medical condition; 2) is undergoing a course of institutional or inpatient care; 3) is scheduled to undergo nonelective surgery; 4) is pregnant and undergoing a course of treatment for pregnancy or 5) is determined to be terminally ill.

**Maintenance of Price Comparison Tool: Division BB, Title 1, Section 114 (Effective for Plan Years beginning January 1, 2022)**

- A health plan must offer price comparison guidance by telephone and provide a price comparison tool on the website (to the extent practicable) of the plan that allows a participant to compare the amount of cost-sharing for which the participant would be responsible.

**Protecting Patients and Improving the Accuracy of Provider Directory Information: Division BB, Title 1, Section 116 (Effective for Plan Years beginning January 1, 2022)**

- A health plan must update its provider directory at least every 90 days and respond to participant request regarding whether a provider is in-network within one business day and retain record of the communication in the participant's file for at least two years following the response. A participant who relies on incorrect information or the information wasn't timely provided to the participant will only be liable for the in-network cost sharing amounts.

- A health plan must post on its website and include in each explanation of benefits information that an out-of-network provider of emergency services and non-emergency services provider by an out-of-network provider in an in-network facility may not balance bill for their services.

## TITLE 1- TRANSPARENCY

### Increasing Transparency by Removing Gag Clauses on Price and Quality Information: Division BB, Title II, Section 201

- A health plan may not enter into an agreement with a health care provider, a network of providers, TPA or other service providers that offers access to a network that restricts the health plan from disclosing provider specific costs, quality of care or accessing electronic de-identified claims data. A health care provider, network, TPA or service provider may place reasonable restrictions on the public disclosure of such information. A group health plan must annually report compliance with this provision. There is no effective date stated in the Act for this provision.

### Disclosure of Direct and Indirect Compensation for Brokers and Consultants: Division BB, Title II, Section 202

- A broker or consultant to an ERISA group health plan must disclose in writing any direct or indirect compensation that it receives from a provider of services to the health plan.

### Strengthening Parity in Mental and Substance Use Disorder: Division BB, Title II, Section 203

- A health plan must provide comparative analysis of non-quantitative treatment limitations (NQTL) that is applied for medical and surgical benefits and mental health and substance abuse benefits. The Secretaries of Labor, Health and Human Services and Health and Treasury will develop regulations and guidance for this provision within 18 months from the enactment of Act. However, the requirement to perform this comparative analysis appears to be effective February 10, 2021.

### Reporting on Pharmacy Benefits and Drug Costs: Division BB, Title II, Section 204

- A health plan must report pharmacy benefits, drug cost and manufacturer rebate information (including 50 most dispensed drugs and 50 most costly drugs) to the Secretaries of Labor, Health and Human Services and Health and Treasury. The first report is due no later than 1 year of enactment of the Act and subsequent reports are due June 1 of each year.