Transparency in Coverage (TiC) and Consolidated Appropriations Act (CAA)

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This document is an informational and educational summary only. Please refer to the regulations for official requirements and note that ruling and effective dates are subject to change. Requirements may be different for plans grandfathered under ACA regulations and for ERISA vs non-ERISA plans.

Requirement	Effective Date	Requirements
Transparency in Coverage (TiC)		
Machine Readable File[1]	7/1/2022	Group health plans and insurers are required to post on their website machine readable files: • One file containing rates for all covered items and services between the plan or insurer and all in-network providers • One file containing allowed amounts for billed charges from out-of-network providers • *Delayed pending further rule making: One file containing negotiated rates and historical payment net prices for all covered prescription drugs at the pharmacy location level*
Price Comparison Tools[1]	1/1/2023	Internet-based price comparison tool (or disclosure on paper, upon request) allowing an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for 500 items and services.
Price Comparison Tools[1]	1/1/2024	Internet-based price comparison tool (or disclosure on paper, upon request) allowing an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for all items and services.
Consolidated Appropriations Act (CAA) – Title I: No Surprise Act		

Medical Billing and Independent Dispute Resolution[2]	1/1/2022	Aims to protect patients from surprise medical bills
		• Private health plans must cover out-of-network claims and apply in-network cost sharing
		  ○ Applies to job-based and non-group plans, includes grandfathered plans
		• Providers cannot bill patients more than in-network cost sharing amount for surprise medical bills
		• Establishes a process to help determine the price for surprise, out-of-network medical bills, starting with negotiations between the plan and provider. If a negotiation is not meet, process will move to an independent dispute resolution (IDR)
		• Protection applies to:
		  ○ Most emergency services
		  ○ Post-emergency stabilization services
		  ○ Non-emergency services provided at in-network facilities

Plan or Insurance Identification Cards[1]	1/1/2022	Require plans and issuers to include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.

Good Faith Estimates (GFE)[3]	1/1/2022
	Partially Delayed
		• Health care providers and facilities must provide a GFE of expected charges to health plans or individuals upon an individual's scheduling of items or services, and it is under the authority of the Department of Health and Human Services ("HHS"). Providers and facilities must give this estimate three days in advance or no later than one day after scheduling
		• The good faith estimate will also include items or services reasonably expected to be provided along with the primary item(s) or service(s), even if the individual will receive the items and services from another provider or another facility.
		• GFE Requirements
		  ○ Patient name and date of birth
		  ○ Description of primary item or service along with date of service
		  ○ Itemized list of items or services
		  ○ Diagnoses codes
		  ○ Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented
		• *As it relates to a provider's requirement to provide a good faith estimate to health plans, HHS will defer enforcement of this requirement until rulemaking is issued to fully implement it. Any future rulemaking will have a prospective effective date. Currently this rule only applies to individuals requesting a GFE from a provider.*

Advanced Explanation of Benefits[1]	1/1/2022
	Delayed
		• Require plans and issuers, upon receiving a GFE, to send a participant, beneficiary, or enrollee an Advanced Explanation of Benefits notification in clear and understandable language.
		• The notification must include:
		  ○ the network status of the provider or facility
		  ○ the contracted rate for the item or service, or if the provider or facility is not a participating provider or facility, a description of how the individual can obtain information on providers and facilities that are participating
		  ○ the GFE received from the provider
		  ○ a GFE of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate received from the provider
		  ○ disclaimers indicating whether coverage is subject to any medical management techniques.

		• The notice also must indicate that the information provided is only an estimate, is subject to change, and any other information or disclaimer the plan or coverage determines appropriate. • *In connection with HHS' decision to defer enforcement of the good faith estimate requirement, the Departments will defer enforcement of this requirement until future rulemaking is issued to implement this provision. Any future rulemaking will have a prospective effective date.*
Continuity of Care[1]	1/1/2022 *Delayed*	• Individual with benefits under a group health plan, individual health plan, or health insurance issuers have established continuity of care. • Protections ensure continuity of care where changes in contractual relationships result in change of provider or facility network status. • *The Departments intend to issue regulations on this provision, but not until after the January 1, 2022 effective date. Until further rulemaking is issued, plans are expected to implement this provision using a good faith, reasonable interpretation of the statute.*
Consolidated Appropriations Act – Title II: Transparency		
Plan Attestation	12/27/2022	The attestation functions as a statement by the plan fiduciary that all facets of the CAA have been applied to the applicable plans, that the guidelines have been adhered to, and that the plan has made a good faith effort to expend plan assets in a prudent manner on behalf of the plan participants and their beneficiaries. • At present, the exact format remains unclear. For large group health plans, the attestation could take the form of an additional Schedule added to the Form 5500. For plans not required to file a Form 5500, it is anticipated that some "template" will be available to plan sponsors. • The first attestation is due by December 27, 2022, for plan years 2020 and 2021
Prohibiting Gag Clauses[1]	12/27/2021	Prohibit plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from: • providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; and • electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and • sharing such information, consistent with applicable privacy regulations. In addition, plans and issuers must submit annually to the Departments an attestation of compliance with these requirements. The Departments will issue implementation guidance to explain how plans should submit their attestation of compliance and anticipate collecting attestations in 2022.

		The Departments do not intend to issue regulations on this provision, which is self-implementing. Plans are expected to implement this provision using a good faith, reasonable interpretation of the statute. Employers should address compliance with this provision in its new contracts and contract renewals with third party administrators and other service providers with respect to its group health plans.
Provider Directories	1/1/2022	Intended to protect participants, beneficiaries, and enrollees with benefits under a plan or coverage from surprise billing. • These provisions generally require plans and issuers to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status. • If the individual was provided inaccurate information by the plan or issuer under the required provider directory or response protocol, the plan must pay it as in-network and not impose more cost sharing to the individual. The Departments intend to issue regulations, but not until after the January 1, 2022 effective date. Until further rulemaking is issued, plans are expected to implement this provision using a good faith, reasonable interpretation of the statute.
Parity Non-Quantitative Treatment Limitations (NQTL) Program[4]	2/10/2022	Requires that group health plans or health insurance issuers offering group or individual health insurance coverage that provide both medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits and that impose NQTLs on MH/SUD benefits perform and document comparative analyses of the design and application of their NQTLs.
Medical Cost and Drug Spend Reporting[5]	12/27/2022	Requires insurance companies and employer-based health plans to submit information about: • Spending on prescription drugs and health care services • Prescription drugs that account for the most spending • Drugs that are prescribed most frequently • Prescription drug rebates from drug manufacturers • Premiums and cost-sharing that patients pay

Sources

1. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf
2. https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/
3. https://www.cms.gov/files/document/gfe-and-ppdr-requirements-slides.pdf
4. https://www.cms.gov/files/document/mhpaea-nqtl-presentation-non-federal-governmental-plans.pdf
5. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection