TCR CAA Timeline

Law/Rule	Description	Effective Date Applies To	Responsibility	Status
Transparency in Coverage – Machine Readable Files	Plans must make public the following information online using three machine-readable files. 1. In-network rates 2. Out-of-network allowed amounts and billed charges 3. Rx drug negotiated rates	Plan years beginning on or after January 1, 2022 Non-grandfathered Group Health Plans and Insurers Does not apply to grandfathered plans, account-based plans, excepted benefits (dental/vision), short-term limited duration insurance or retiree-only plans	Enterprise (TPAs to assist with data collection)	Collecting data from networks and PBMs HClactive to assist Enforcement deferred until July 1, 2022 for in-network rates and out-of-network amounts and billed charges Enforcement deferred pending any further rulemaking for Rx drug negotiated rates
Transparency in Coverage – Transparency Tool	Plans must provide cost-sharing information and rate information that is accurate at the time of the request to participants on a search¬able, internet-based, self-service tool; and must provide a notice when the tool is used.	Plan years beginning on or after January 1, 2023 for 500 items and services. All services by January 1, 2024 Non-grandfathered Group Health Plans and Insurers Does not apply to grandfathered plans, account-based plans, excepted benefits (dental/vision), short-term limited duration insurance or retiree-only plans	Enterprise	Investigating alternative solutions for TPAs not on HClactive Enforcement deferred until January 1, 2023 HClactive designing a pricing tool
Consolidated Appropriations Act: Transparency Tool	Plans must offer price comparison guidance by telephone and make available on the public website of the plan or issuer a price comparison tool that allows an enrolled individual to compare the amount of cost-sharing that the individual would be responsible for paying for items and services by a participating provider, by geographic region.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	Enterprise	Enforcement deferred until January 1, 2023 HClactive designing a pricing tool
Advanced Explanation of Benefits Disclosure	After receiving notice from a provider/facility of estimated charges, plans must provide the participant an Advanced Explanation of Benefits (EOB) including rate and cost-sharing information. EOB should be provided within 3 days or receiving the estimate from the provider if scheduled 10+ days ahead. Within 1 day, if scheduled within 3-10 days.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	Enterprise	Enforcement deferred; the Departments intend to undertake notice and comment rulemaking
Reporting on Rx Drug Costs	Plans must submit Rx drug cost information to the federal government.	No later than December 27, 2021; for each year thereafter no later than June 1	TPA	Enforcement deferred pending the issuance of regulations or further guidance
Disclosure on Patient Protections against Balance Billing	Publicly disclose on a public website and include on each EOB a disclosure relating to prohibitions on balance billing in certain circumstances.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	Plans	Language added to website and EOB
No Surprise Act: Emergency Services	Plans must cover emergency services at non-participating facility, services/items provided by non-participating provider at a participating facility, or non-participating provider air ambulance services with the same participant cost-sharing whether the services are from a participating or non-participating provider or facility. Providers and facilities are banned from balance billing.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	TPA	

Law/Rule	Description	Effective Date Applies To	Responsibility	Status
No Surprises Act: Independent Dispute Resolution	Plans must pay non-participating providers within 30 days or deny payment. Parties may request independent dispute resolution.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	TPA	
No Surprises Act: Qualifying Payment Amount	Federal Agencies must issue rulemaking to establish the methodology to determine "qualifying payment amount," differentiating by large and small group markets.	Plan years beginning on or after January 1, 2022	TPA	
ID Card	Plans must include plan deductibles, out-of-pocket maximums and consumer assistance contact information (phone number and website) in clear writing on any physical or electronic plan or insurance identification card.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	Enterprise will provide template. TPAs to implement with ID Card vendor.	Template has been provided to TPAs. TPAs are to submit a copy of the ID Card for legal review.
External Review	External review applies to adverse determinations concerning emergency services or air ambulance services covered by the No Surprises Act.	No later than January 1, 2022 Unclear – probably non-grandfathered Group Health Plans and Insurers	TPA	
Notice of Continuity of Care	Plans must notify individuals who are "continuing care patients" of the right to continue to receive care after termination of a provider/facility contract. The notice places rules on contract terms and plan rules.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	TPA	
Provider Directory	Plans must create a process to verify the accuracy of their provider database and update at least every 90 days. If not verified, provide must be removed. If the participant was informed the provider was a participating provider when in fact a non-participating provider, the plan cannot impose higher cost-sharing that would apply for participating provider, and must apply the participating deductible and OOP.	Plan years beginning on or after January 1, 2022 Group Health Plans and Insurers	Enterprise	HCIactive to assist.
Gag Clauses Prohibited	Plans may not enter into an agreement with a provider, network, TPA or other service provider that would directly or indirectly restrict the plan from providing provider-specific cost or quality information to referring providers, plan sponsors, participants or electronically accessing de-identified claims. Requires annual attestation of compliance.	Effective December 27, 2020 Group Health Plans and Insurers	TPA	
Disclosure of Broker and Consultant Compensation	Amends ERISA Section 408(b)(2) to require disclosure of compensation.	December 27, 2021, with transition period for executed contracts ERISA-governed plans	TPA	Most TPAs report that they already disclose.
Mental Health Parity and Addiction Equity Act (MHPAEA) assessment required	Plans must perform and document comparative analyses of the design and application on non-quantitative treatment limitations (NQTLs) and make them available upon request to the secretary of the DOL and HHS as applicable.	February 10, 2021	TPA	Template created as part of the compliance workgroup. Stored on Teams.
Response Protocol Regarding Participating Provider Status	Must respond to member requests for information (regarding whether a provider or facility has a contractual relationship to furnish items and services.	Plan years beginning on or after| January 1, 2022 Group Health Plans and Insurers	TPA	