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ADVANCING SELF-FUNDED HEALTHCARE

Implementation of Certain Provisions of the No Surprises Act and Title II (Transparency) of the Consolidated Appropriations Act 2021

PROVISIONS	DESCRIPTIONS	EFFECTIVE DATE	APPLIES TO	FUTURE GUIDANCE
Transparency In Coverage (TiC) Public Posting of Machine Readable Files	Make public machine-readable files disclosing in-network rates and out-of-network allowed amounts and billed charges	Enforcement deferred until July 1, 2022 for plan years beginning on or after January 1, 2022. For 2022 plan years beginning subsequent to July 1, 2022, plans should post the machine-readable files in the month in which the plan year begins. Prescription drug pricing in machine-readable files exception – enforcement is delayed pending further rulemaking.	Plans and Insurers	TiC rules are final. No further guidance expected.
No Surprises Act (CAA) Price Comparison Tools	Offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the	This requirement is applicable with respect to plan years beginning on or after January 1, 2022. However, the Departments will defer enforcement of this requirement until plan years beginning on or after January 1, 2023.	Plans and Issuers	Departments intend to propose rulemaking and seek public comment.

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	individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider.			
Transparency in Coverage (TiC) Self-Service Tool Component	The TiC Final Rules require plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, **upon request**.	This information must be available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services listed in the TiC final rules. Information for all covered items and services, for plan or policy years beginning on or after January 1, 2024.	Plans and Issuers	Departments intend to propose rulemaking and seek public comment regarding, among other issues, whether compliance with the internet-based self-service tool requirements of the TiC Final Rules satisfies the analogous requirements set forth in No Surprises Act Price ComparisonTools. These provisions, however, add a requirement that was not imposed under the TiC Final Rules: that price information also must be provided over the telephone upon request.

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				Therefore, the Departments intend to propose rulemaking requiring that the same pricing information that is available through the online tool or in paper form, as described in the TiC Final Rules, must also be provided over the telephone upon request.
Transparency in Plan or Insurance Identification Cards	Physical or electronic plan or insurance identification (ID) cards are to include information on any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.	These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.	Plans and Issuers	No future guidance will be issued prior to effective date. Future rulemaking addressing implementation of the ID card requirements, including how plans and issuers offering complex plan and coverage designs should represent information on an ID card. Pending future rulemaking, plans and issuers are expected to

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				implement the ID card requirements using a good faith, reasonable interpretation of the law.
Good Faith Estimate	Requires that providers and facilities provide good faith estimate information for individuals enrolled in a health plan or coverage and seeking to submit a claim for scheduled items or services to their plan or coverage. Consumers have existing recourse to challenge out-of-pocket costs through the DOL internal claims and appeals and external review process under existing law and regulations.	Pending rulemaking	Providers and facilities that provide services to plan participants covered by benefit plans	HHS intends to issue regulations implementing good faith estimate requirements. Rulemaking to fully implement this requirement is not likely before January 1, 2022.
Advanced Explanation of Benefits	Send an AEOB to participants including numerous items after receiving a "good faith estimate."	Enforcement deferred to unspecified time.	Plans and Issuers	Notice and comment rulemaking is expected, including establishing appropriate data transfer standards.
Prohibition on Gag Clauses on Price and Quality Data	ERISA prohibits plans and issuers from entering into an agreement offering access to a network of providers that would directly or indirectly restrict the	December 27, 2020 (the date of enactment of the CAA).	Network or association of providers, third-party	Further guidance is expected in 2022 to explain how plans and issuers should submit their

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	plan or issuer from providing provider cost or quality of care information; from electronically accessing claims data; and providing an attestation of compliance.		administrators, and other service providers	attestations of compliance and anticipate beginning to collect attestations starting in 2022.
Protecting Patients and Improving the Accuracy of Provider Directory Information	Establishes standards related to provider directories that are intended to protect participants, beneficiaries, and enrollees from surprise billing. The provisions require plans and issuers to establish a process to update and verify the accuracy of provider directory information and to establish protocols for responding to participant and beneficiary requests by telephone and electronic communication. Plans and issuers must also post certain disclosures regarding balance billing protections on a public website of the plan or issuer, and include certain information on each Explanation of Benefits (EOB) for an item or service.	The disclosure requirements are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.	Plans and Issuers	The Departments will undertake notice and comment rulemaking to implement the provider directory requirements. Rulemaking will not be issued until after January 1, 2022. Plans and issuers are expected to implement these provisions using a good faith, reasonable interpretation of the statute. The Departments will not deem a plan or issuer to be out of compliance as long as the plan or issuer imposes only a cost-sharing amount that is not greater than the

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				cost-sharing amount by an in-network provider in a case where the plan participant received incorrect information regarding the provider's network status from the plan's provider directory.
Continuity of Care	The section establishes continuity of care protections that apply in the case of an individual with benefits under a group health plan or group or individual health insurance coverage offered by a health insurance issuer. These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status.	These provisions are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.	Group health plans or group or individual health insurance coverage offered by a health insurance issuer	The Departments intend to undertake notice and comment rulemaking to implement the continuity of care requirements, but do not expect to do so until after January 1, 2022. Until rulemaking to fully implement these provisions is adopted and applicable, plans, issuers, providers, and facilities are expected to implement the requirements using a good faith, reasonable

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				interpretation of the statute.
Grandfathered Health Plans	Grandfathered group health plans are subject to the requirements of the CAA. The CAA changed and clarified 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.	Plans years effective on or after January 1, 2022.	Grandfathered group health plans	No guidance needed.
Reporting on Pharmacy Benefits and Drug Cost	The section requires plans and issuers to submit data related to prescription drug expenditures to the Departments. This information includes (among other information) the 50 most frequently dispensed brand prescription drugs, and the total number of paid claims for each such drug; the 50 most costly prescription drugs by total annual spending, and the annual amount spent by the plan or coverage for each such drug; and the 50 prescription drugs with the greatest increase in plan	The Departments deferred enforcement of the requirement by the first deadline for reporting on December 27, 2021 or the second deadline for reporting on June 1, 2022, pending the issuance of regulations or further guidance. Anticipate reporting for 2020 and 2021 data by Dec. 27, 2022.	This requirement applies to non-grandfathered plans. It does not apply to church plans.	Until regulations or further guidance are issued, the Departments strongly encourage plans and issuers to start working to ensure that they are in a position to be able to begin reporting the required information with respect to 2020 and 2021 data by December 27, 2022.

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	expenditures over the plan year preceding the plan year that is the subject of the report, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year.			
Notice and Consent Exceptions to Balance Billing Protections	Nonparticipating providers and nonparticipating emergency facilities will be able to balance bill in certain nonemergency situations if they provide notice and receive consent from participants.	Plan years beginning on or after January 1, 2022.	Providers billing for certain nonemergency situations and services.	Interim Final Rule released on 7/2/2021 with request for comments. Guidance addressing the comments possible at some point in the future.
Qualifying Payment Amount (QPA)	The QPA will be used to determine the amount patients are required to pay for certain out-of-network services. The QPA will also be used to determine the initial plan payments for emergency services and for non-emergency services provided by out-of-network providers at certain network facilities.	Plan years beginning on or after January 1, 2022	Plan, Issuers, Plan Participants	Interim Final Rule released on 7/2/2021 with request for comments. Guidance addressing the comments expected at some point in the future.
Independent Dispute Resolution	The federal independent dispute resolution (IDR) process will be used by out of network providers, facilities, providers of air ambulance services,	IDR process regs are generally applicable to group health plans and health insurance issuers for	Providers, Facilities, Air Ambulance	Interim Finale Rule was released 9/30/2021, with comments due 12/6/2021. Future guidance addressing

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	plans, and issuers in the group and individual markets to determine the out of network rate for applicable items or services covered by the No Surprises Act after an unsuccessful open negotiation.	plan and policy years beginning on or after January 1, 2022. The rules regarding the certification of independent dispute resolution entities are effective from the date the rule was published in the Federal Register, 10/7/2021.	Providers, Plans, Issuers	the comments possible at some point in the future.