

The Surprises Continue: The Biden Administration Delays Implementation of Certain Provisions of the No Surprises Act and Transparency in Coverage Final Rules Applicable to Providers and Insurers

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In a [FAQ](#) published on August 20, 2021, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the “Departments”) significantly delayed implementation of statutory requirements on surprise billing and price transparency, which we had previously summarized in a series of blog posts throughout this past year:

- [No Surprises: Congress Enacts Surprise Bill Law and Adds Mandatory Billing Transparency](#)
- [No Surprises in Initial No Surprises Act Regulations](#)
- [New Federal Transparency Requirements Impacting Health Providers and Plans](#)

Specifically, the FAQs focus on the implementation of certain provisions of the Affordable Care Act’s (the “ACA’s”) [Transparency in Coverage Final Rules](#) (the “TiC Final Rules”) and certain provisions of title I (the No Surprises Act) and title II (Transparency) of Division BB of the [Consolidated Appropriations Act, 2021](#) (the “CAA”).

We have summarized the significant implementation requirements below.

Transparency in Coverage

Under the TiC Final Rules, commercial health plans are required to disclose negotiated rates and historical net prices for covered prescription drugs in a machine readable file. The Departments announced that they will defer enforcement of this requirement pending future rulemaking, recognizing stakeholder concerns about compliance feasibility, the potentially duplicative nature of various disclosure requirements, and that litigation challenging the requirement had already commenced.

Moreover, commercial health plans are required to disclose in-network provider rates for covered items and services and out-of-network allowed amounts and billed charges for covered items and services. The Departments announced that instead of enforcing these requirements as of January 1, 2022, enforcement will be delayed for a period of 6 months until July 1, 2022, due to concerns about the tight deadline given the amount of work required.

Price Comparison

Under the TiC Final Rules, health plans are required to provide price comparison information through an internet-based self-service tool and in paper upon request. This information must be available for plan (or policy) years beginning on or after January 1, 2023, with respect to 500 identified items and services and with respect to all covered items and services for plan (or policy) years beginning on or after January 1, 2024.

The CCA also requires plans to maintain online price comparison tools that will allow patients to compare expected out-of-pocket costs for items and services across multiple providers. Health plans also will need to provide price comparisons over the phone. This requirement was set to become effective as of January 1, 2022.

In the FAQs, the Departments acknowledged that the price comparison requirements under the TiC Final Rules and under the CCA are largely duplicative; as a result, the Departments intend to propose rulemaking and seek public comment regarding, among other issues, whether compliance with the requirements of the TiC Final Rules satisfy the analogous requirements set forth in the CCA. The Departments will issue rules related to the required telephonic availability of the data. The Departments will defer enforcement of the CCA requirement until 2023.

Good Faith Estimates

Beginning January 1, 2022, the CCA requires providers (individual practitioners and facilities) to send an individual's health plan a "good faith estimated amount" of scheduled services, including any expected ancillary services and the expected billing and diagnostic codes for all items and services to be provided. In the case that the individual is not enrolled in a health plan or coverage, the provider must provide this notification to the individual.

The FAQs state that the complexities of this requirement make it virtually impossible for providers to comply by January 1, 2022. Therefore, the Departments decided to defer enforcement of this requirement until future rulemaking.

Advanced Explanation of Benefits

Under the CCA, once the provider sends the health plan the "good faith estimated amount" for a given patient, the health plan is then obligated to send enrollees an "Advanced Explanations of Benefits" ("AEOB") prior to scheduled care (or upon patient request). The health plan must provide the AEOB by mail or electronically (based on patient preference) either within three business days of receiving a request or a notice that a service has been scheduled if the 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.

This requirement was set to take effect on January 1, 2022, but the Department noted that compliance is likely not possible by that time; therefore, the Departments intend to undertake notice and comment rulemaking in the future to implement this provision and in the meantime, will defer enforcement.

Provider Directories

The CCA requires health plans to establish and maintain an online directory listing the names of contracted providers, addresses, specialties, telephone numbers, and digital contact information. The information must be verified and updated at least every 90 days, but must be updated within two business days of receiving new information from a provider. If the health plan is unable to verify the accuracy of a provider's information, the health plan must have procedures for removing these providers.

The FAQs note that the Departments intend to undertake notice and comment rulemaking to implement the provider directory requirements, but rulemaking will not be issued until after January 1, 2022 (the original effective date of such requirement). However, until further rulemaking is issued, health plans are still expected to implement these provisions using a good faith, reasonable interpretation of the statute.

Other requirements of the CCA and TiC Final Rules that are not subject to action delaying the effective date (e.g. transparency in plan member identification cards, prohibition of gag clauses, balance billing rights notice, and continuity of care requirements) remain subject to the original effective dates described in the CCA and TiC Final Rules, and providers are advised to implement the rule based on a “good faith, reasonable interpretation of the law” (although in the FAQs, the Departments have effectively provided a safe harbor for certain actions that they will deem compliant such as information on member identification cards, and the use of model balance billing rights notice).

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