Transparency Rule & No Surprises Act Chart

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The **No Surprises Act** was signed into law December 27, 2020, as part of the Consolidated Appropriations Act of 2021 to protect participants in health benefit plans from surprise medical bills for emergency and non-emergency medical care, including air ambulance services. The No Surprises Act applies to employer-sponsored group health plans, including self-funded plans, fully insured plans, and grandfathered plans. It does not apply to HRA plans (or other account-based plans), voluntary dental and vision plans administered under a separate policy or agreement, or retiree-only plans.

The **Transparency Rule** was signed into law November 12, 2020 and requires plans and insurance issuers to disclose cost-sharing information, negotiated rates for in-network providers, and allowed amounts for out-of-network providers. The Transparency Rule applies to employer-sponsored group health plans and health insurance issuers in the group and individual market. It does not apply to grandfathered health plans, HRA/HSA Plans, retiree only plans, or voluntary dental and vision plans administered under a separate policy or agreement. A self-insured plan can delegate compliance with the Transparency Rule to a third-party administrator (TPA) but will be liable for the TPA's non-compliance. Sponsors of fully insured plans are permitted to enter into a written agreement delegating compliance to the health insurance issuer; the issuer will then be liable for noncompliance.

Limited guidance regarding out-of-network (OON) emergency and balance-billing was published on July 13, 2021. The July guidance stated that the federal government intends to issue regulations regarding transparency in plan and insurance identification cards, continuity of care, accuracy of provider network directories, prohibition on gag clauses, and pharmacy benefit and drug cost reporting. However, rulemaking regarding some of these provisions might not occur until after January 1, 2022. Regulations issued after January 1, 2022 will include a prospective applicability date that provides plans, issuers, providers, and facilities a reasonable amount of time to comply with new or clarified requirements. Until such regulations are issued plan sponsors are expected to implement the requirements of the No Surprises Act and Transparency Rule using a good faith, reasonable interpretation.

If you have any questions, please contact Brandie Barrows at bbarrows@taylorenglish.com.

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Requirement	Effective Date
No Surprises Act Plans and insurance issuers subject to the Mental Health Parity and Addiction Equity Act must perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTL) and make them available upon request to the Secretary of the Department of Labor (DOL).	February 10, 2021
No Surprises Act Plans and insurance issuers are required to disclose broker and consultant compensation.	December 27, 2021, with transition period for contracts executed prior to the Effective Date.
Transparency Rule Plans and insurance issuers must make the following information public using three machine readable files: (1) In-Network (IN) Rates, (2) Out-of-Network (OON) Allowed Amounts, and (3) Prescription Drug Negotiated Rates.	Plan Years beginning on or after January 1, 2022

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Requirement	Effective Date
No Surprises Act Plans and insurance issuers must cover emergency services and providers at OON facilities, OON providers at an IN facilities, or OON air ambulances with the same cost-sharing whether or not the services are provided by an IN or OON provider or facility. Providers are prohibited from billing a patient for the difference between the total cost of services being charged and the amount the insurance pays (i.e., "balance billing"). This requirement does not preempt state balance billing laws that provide greater protections to plan participants. *Resolving Payment Disputes*: A provider or facility may initiate negotiations with the plan or insurance issuer to contest payment for services within 30 days of receiving initial payment. Open negotiation will last 30 days. If there is no resolution either party can initiate an independent review process (IDR) using an IDR entity certified by the Secretaries of Labor, HHS and Treasury.	Plan Years beginning on or after January 1, 2022
No Surprises Act Plans must include plan deductibles, out-of-pocket (OOP) 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
No Surprises Act The External Review process now applies to adverse determinations concerning emergency services or air ambulance services covered by the No Surprises Act.	Plan Years beginning on or after January 1, 2022

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Requirement	Effective Date
No Surprises Act After receiving notice from a provider/facility of estimated charges, plans and insurance issuers must provide the participant with an Advanced Explanation of Benefits.	Plan Years beginning on or after January 1, 2022
No Surprises Act Plans and insurance issuers must notify individuals who are "continuing care patients" of the right to continue to receive care after termination of a provider/facility contract (serious conditions, pregnancy).	Plan Years beginning on or after January 1, 2022
No Surprises Act Plans and insurance issuers must offer price comparison guidance by telephone and make available on a 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, and by geographic region.	Plan Years beginning on or after January 1, 2022

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Requirement	Effective Date
No Surprises Act Plans and insurance issuers must create a process to verify the accuracy of their provider database and update it every 90 days. If the participant was informed that the provider was a participating provider when in fact they were a non-participating provider, the plan cannot impose higher cost-sharing than would apply for a participating provider and must apply the participant cost share to their in-network deductible and OOP maximum.	Plan Years beginning on or after January 1, 2022
No Surprises Act Plans and insurance issuers may not enter into an agreement with a provider, network, or third-party administrator 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 or participants, electronically accessing de-identified claims, or sharing information with a HIPAA business associate.	Unclear
No Surprises Act Plans and insurance issuers must submit prescription drug cost information to the federal government.	No later than December 27, 2021; no later than June 1 for subsequent years (starting in 2022)

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Requirement	Effective Date
Transparency Rule Plans and insurance issuers must provide cost-sharing information that is accurate at the time of the request to participants on a searchable, internet-based, self-service tool, and must provide a notice when the tool is used. This applies to 500 specific items and services in plan years beginning on and after January 1, 2023, and to all items and services in plan years starting on or after January 1, 2024. Information includes, but is not limited to estimated cost sharing, accumulated amounts, IN rates, OON allowed amounts, items and services content list, notice of prerequisites to coverage, and a disclosure notice.	Plan Years beginning on or after January 1, 2023

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