# Timeline and Application of No Surprise Billing and Transparency Laws and Rules

This chart compiles all recent laws and regulations concerning the No Surprises Act (enacted December 30, 2020) and Transparency in Coverage regulations as of April 1, 2022, including FAQ 49 published by the Employee Benefits Security Administration. Pending further guidance, plan sponsors must implement the No Surprises Act using a good-faith, reasonable interpretation of the law. Plan sponsors should consult with legal counsel as to the application of any particular law or regulation to their health plan.

| Law/Rule | Description | Effective Date | Applies To |
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| Hospital price transparency final rule | Hospitals must make public their standard charges online in two ways:<br>1. A comprehensive machine-readable file that includes charges for all hospital items and services<br>2. A consumer-friendly display that includes the charges for at least 300 "shoppable" services | January 1, 2021 | Hospitals |
| Group health plan transparency rule for public disclosure | Plans must make public the following information online using three machine-readable files:<br>1. In-network rates<br>2. Out-of-network allowed amounts and<br>3. Prescription drug negotiated rates | Originally, plan years beginning on or after January 1, 2022<br>Enforcement deferred until July 1, 2022 for in-network rate and out-of-network allowed amount files<br>Enforcement delayed until future rulemaking for prescription drug negotiated rate file | Non-grandfathered group health plans and health insurers<br>Does not apply to grandfathered plans, account-based plans, excepted benefits (e.g., dental/vision), short-term limited duration insurance or retiree-only plans |
| Group health plan transparency rule for disclosures to participants and beneficiaries | Plans must provide cost-sharing information and rate 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. | Plan years beginning on or after January 1, 2023 for 500 items and services<br>Plan years beginning on or after January 1, 2024 for all covered items and services<br>Awaiting regulations on similar No Surprises Act requirement | Non-grandfathered group plans and health insurers<br>Does not apply to grandfathered plans, account-based plans, excepted benefits (e.g., dental/vision), short-term health limited duration insurance or retiree-only plans |

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| Law/Rule | Description | Effective Date | Applies To |
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| No Surprises 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<br>Interim Final Rule "Part 1" published July 13, 2021<br>Interim Final Rule "Part 2" published October 7, 2021 | Group health plans* and health insurers |
| 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 health insurers |
| No Surprises Act: qualifying payment amount | Federal agencies issue rulemaking establishing the methodology to determine "qualifying payment amount," differentiating by large and small group markets. | Plan years beginning on or after January 1, 2022 | Group health plans and health insurers |
| ID card requirement | 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 | Group health plans and health insurers |
| 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 | Group health plans and health insurers |

* Covered group health plans generally include those subject to federal health care reforms under ERISA, the Internal Revenue Code and the Public Health Service Act. Certain health plans otherwise excepted from federal health laws, e.g., small group health plans, excepted benefits and retiree-only plans, would appear to be exempt from these requirements, but applicability should be clarified in regulatory guidance. It appears that the requirements of this law apply to grandfathered group health plans, but this should also be addressed in regulatory guidance.

| Law/Rule | Description | Effective Date | Applies To |
|---|---|---|---|
| Provider fee estimate | When a patient schedules a service, providers must provide a timely notification in clear and understandable language of the good-faith estimate of the expected charges for providing items and services to the plan or insurer (or if uninsured, the individual). | Enforcement delayed until future rulemaking | Healthcare providers and facilities |
| 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. | Enforcement delayed until future rulemaking | Group health plans and health insurers |
| 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 health insurers |
| Price comparison tool required | 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, 2023<br>Awaiting regulations | Group health plans and health insurers |
| Provider directory requirements | Plans must create a process to verify the accuracy of their provider databases and update at least every 90 days. 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 health insurers |

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| 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 | December 27, 2020<br>Implementation guidance will be issued in the future on the attestation requirement, which is expected to begin in 2022 | Group health plans and health insurers |
| Reporting on prescription drug costs | Plans must submit prescription drug cost information to the federal government.<br>First reports due December 27, 2022 for 2020 and 2021 data | Originally, no later than December 27, 2021; for each year thereafter, no later than June 1<br>Deferred until December 27, 2022 | Group health plans and health insurers |
| Reporting on Air Ambulance costs | Plans must submit information to the federal government on air ambulance costs | Deferred until future regulations | Group health plans and health insurers |
| 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 |
| Mental Health Parity and Addiction Equity Act (MHPAEA) assessment required | Plans must perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) and make them available upon request to the secretary of the DOL or HHS as applicable | February 10, 2021 (45 days after enactment) | Plans subject to the MHPAEA |

For additional information, refer to these compliance insights:

- January 14, 2021 compliance insight on the health provisions in the No Surprises and the Consolidated Appropriations Act, 2021
- January 14, 2021 compliance insight on the expansion of MHPAEA
- July 14, 2021 compliance insight on the interim final rule
- August 23, 2021 compliance insight on FAQ 49
- November 9, 2021 on 2022 independent dispute resolution
- January 5, 2022 on the Qualifying Payment Amount
- March 1, 2022 on continuing No Surprises Act compliance despite a United States District Court decision

If you have questions about the insights noted above or would like more information about the information in this chart, please contact your Segal consultant or Kathy Bakich, Senior Vice President and Health Compliance Practice Leader, at kbakich@segalco.com or 202.833.6494.

Segal can be retained to work with plan sponsors and their legal counsel on compliance issues.



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