Departments Release FAQ Guidance for No Surprises Act and Transparency in Coverage Requirements

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On August 20, 2021, the Departments of Labor, Health and Human Services, and Treasury (together, the "Departments") released Frequently Asked Questions to complement the No Surprises Act and Transparency in Coverage provisions of the Consolidated Appropriations Act (CAA). These FAQs give health plans and issuers guidance on the following items:

- **Transparency in Coverage (TiC) Machine-Readable Files,** notably indicating that the Departments will defer enforcement of many TiC requirements to make public machine-readable files of in-network and out-of-network rates until July 1, 2022.
- **Price Comparison Tools,** noting that the Departments intend to promulgate a rule requiring that pricing information is available online or on physical paper and also is available telephonically.
- **Transparency in Plan or Insurance ID Cards,** stating that the Departments will engage in additional rulemaking to address ID card requirements and providing examples of good faith compliance with those requirements.
- **Good Faith Estimates of Expected Charges,** noting that HHS will defer enforcement of the requirement to provide insureds who are seeking to submit a claim with a good faith estimate of their expected charges.
- **Advanced Explanation of Benefits (AEOB),** indicating that additional regulations regarding the AEOB will not be promulgated until after the applicable January 1, 2022 deadline, and as a result, enforcement of the AEOB provisions will be deferred.

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- **Prohibition on Gag Clauses and Quality Data,** confirming that plans and insurers are to implement requirements on gag clauses according to a reasonable, good faith interpretation of the statute.
- **Protecting Patients/Provider Directory Accuracy,** remarking that notice and comment rulemaking will be issued after the applicable January 1, 2022 deadline and that in the interim, the Departments will consider a plan in compliance with provider directory requirements if the plan or issuer imposes a cost-sharing amount that is less than the cost-sharing amount imposed for items or services provided by an in-network provider, and that those cost-sharing amounts count towards an individual's out-of-pocket maximum.
- **Continuity of Care,** requiring that providers utilize a reasonable, good faith interpretation of the statute to implement the continuity of care requirement until additional rulemaking occurs.
- **Grandfathered Health Plans,** confirming that such plans are subject to the CAA.
- **Reporting on Pharmacy Benefits and Drug Costs,** deferring the first and second reporting requirements for pharmacy benefits and drug costs until December 27, 2021, and June 1, 2022, respectively.

These FAQs defer enforcement of many provisions of the CAA and require that plans and issuers implement relevant statutes in good faith to be considered compliant in the interim. Additional rulemaking is expected to occur during the remainder of 2021 and in 2022 as the Departments seek to provide additional clarity on the implementation of the CAA.

For questions about these FAQs or the CAA, please contact Cami Trachtman, Jim Dietz, or any other member of Frost Brown Todd's Health Care Innovation Team.

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