

# Opaque Price Transparency Requirements for Payors and Providers

Article By:

Joseph D. Wheeler

Timothy Cahill

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The only thing crystal clear about health care price transparency requirements at the moment is that the government will continue implementing new price transparency laws, regulations, and rules. This slew of price transparency developments over the past year has resulted in the Departments of Labor, Health and Human Services, and Treasury (collectively, the “Departments”) issuing FAQs on Aug 20, 2021, about the Affordable Care Act, the Consolidated Appropriations Act, 2021, and the Transparency in Coverage Final Rules (TiC Final Rules) regarding the implementation of Part 49 of the Code of Federal Regulations and the price transparency requirements for non-grandfathered group health plans and other private insurance payors.

On Oct. 29, 2020, the Departments issued the TiC Final Rules in response to President Trump’s Improving Price and Quality Transparency in American Healthcare Executive Order, issued June 24, 2019. The TiC Final Rules required non-grandfathered health insurance coverage in the individual and group markets to (i) make available to enrollees personalized out-of-pocket cost information and the underlying negotiated rates for all covered healthcare items and services and (ii) make available to the public three separate machine-readable files that include detailed (a) in-network provider rates; (b) out-of-network allowed amounts, and (c) negotiated rates and historical net prices.

After the TiC Final Rules were promulgated, however, Congress passed the Consolidated Appropriations Act, 2021 omnibus bill, including the No Surprises Act, dramatically altering the health care landscape and prompting the Departments to issue their additional guidance FAQs.

## Payor Price Transparency and Comparison Tool Requirements

Through the FAQs, the Departments announced they will exercise their enforcement discretion and suspend or delay enforcing certain requirements under the TiC Final Rules. Section 204 of the No Surprises Act requires plans and third-party payors to submit specific information to the Departments, including pharmacy benefit and prescription drug pricing information. As a result, the Departments have decided not to enforce the TiC Final Rules requirement to publish pricing information related to prescription drugs out of concerns it will create duplicative reporting requirements. Further, the Departments also announced they will not be enforcing Section 204’s pharmacy benefit and drug

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cost reporting requirements until further guidance is issued. The Departments also recognized that implementing a number of the No Surprises Act requirements while publishing additional pricing information, which would have to be done simultaneously by Jan. 1, 2022, as required by the TiC Final Rules, was likely to create too onerous of a burden for plans and insurers. As a result, the Departments also delayed enforcement of the requirement to publish pricing information for in-network rates and out-of-network allowed amounts and billed charges for the 2021 plan year until July 1, 2022. After which, plans and insurers should publish the required pricing information in the same month that a new plan year begins.

The Departments also noted the significant overlap between the TiC Final Rules' and the No Surprises Act's requirements relating to publishing price comparison tools. The Departments have announced, for now, they will suspend enforcement of the TiC Final Rules requirements, issue new rulemaking, and request additional shareholder input and instead focus on assisting plans and insurers with compliance.

## **No Surprises Act Requirements and Future Rulemaking**

In addition to the clarifications the Departments provided regarding the overlap between the No Surprises Act and the TiC Final Rules, the FAQs also addressed future rulemaking by the Departments for requirements imposed by the No Surprises Act and clarified ongoing requirements until those future regulations are promulgated.

## **Plan and Policy ID Card Requirements**

Section 107 of the No Surprises Act requires plans and insurers to include in clear writing on any plan or insurance identification card any applicable (i) deductibles; (ii) out-of-pocket maximums; and (iii) a telephone number and website address for individuals to seek consumer assistance. The Departments do not currently plan to issue any additional regulations prior to the Jan. 1, 2022, effective date, but they do intend to promulgate future rules addressing these ID requirements for plans and policies that offer complex coverage and designs. Until then, however, the Departments have stated they will not deem any plan or insurer out of compliance so long as any ID card includes (a) a major medical deductible; (b) an out-of-pocket maximum; and (c) a telephone number and website address to allow the beneficiary to access consumer assistance and additional applicable deductibles and out-of-pocket maximums.

## **Good Faith Estimates**

Pursuant to Section 112 of the No Surprises Act, health care providers, and facilities will be required to provide patients, at the time of scheduling, with a good faith estimate of the expected charges for furnishing the service of the item and any other services or items that could reasonably be expected to be provided in conjunction with those scheduled services or items, including those provided by another health care provider or facility. If the patient is enrolled in a plan or has coverage, the provider is required to provide this good faith estimate to the third-party payor, which is then provided to the patient through an Advanced Explanation of Benefits. If the patient is not enrolled in a plan or does not have coverage, then the good faith estimate must be provided to the individual patient. This requirement is scheduled to be effective Jan. 1, 2022.

Currently, the Departments do not intend to issue any additional guidance on this good faith estimate requirement for individuals enrolled in plans or who have coverage prior to Jan. 1, 2022. The

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Departments feel these beneficiaries already have available and existing avenues of recourse to challenge the costs through internal claims, appeals, and external review processes. The Departments will also delay enforcement of this provider requirement to notify the patient's group or insurer of the good faith estimate until additional regulations are promulgated since developing the technical infrastructure to transmit this data is complex.

The Departments do, however, intend to issue additional regulations to implement the good faith estimate requirement for providers as it relates to patients who do not have coverage and are not covered by a plan prior to Jan. 1, 2022. This obligation to provide uninsured patients a good faith estimate and any additional obligations created by the Departments' forthcoming regulations will, as of now, be effective Jan. 1, 2022, as the Departments have not indicated that enforcement of this requirement will be delayed.

## **Advanced Explanation of Benefits**

Section 111 of the No Surprises Act also requires plans and insurers to send a beneficiary an advanced explanation of benefits once the plan or insurer receives a good faith estimate from a health care provider. The advanced explanation of benefits must include: (1) the network status of the provider or facility; (2) the contracted rate for the item or service or, if the provider is not a participating provider, a description of how the individual can obtain information on providers who are participating; (3) the good faith estimate received from the provider; (4) a good faith estimate of the amount the plan or coverage is responsible for paying and the amount of any cost-sharing for which the individual would be responsible for based on the provider's good faith estimate; and (5) disclaimers indicating whether coverage is subject to any medical management techniques. This requirement is effective to plan years beginning on or after Jan. 1, 2022. The Departments, however, will not be enforcing this requirement until the technical infrastructure to transmit the provider's estimate and the plan's or insurer's advanced explanation of benefits is developed and implemented.

## **Additional Future Rulemaking**

In addition to the other portions of the No Surprises Act addressed by the FAQs, the Departments announced that they intend to promulgate additional rules related to price and quality gag clauses, provider directory requirements, plan, and insurer continuity of care requirements, and pharmacy benefit and drug cost reporting. In each case, the forthcoming rulemaking is expected to occur after the Jan. 1, 2022, effective date of the No Surprises Act. The Departments have stated that, generally, so long as the plans, insurers, or providers, as applicable, are implementing the requirements of the No Surprises Act using a good faith, reasonable interpretation of the statute, the Departments would not deem a plan, insurer, or provider out of compliance.

## **Conclusion**

There is a lot on the near-future horizon for plans, insurers, and providers alike to prepare for with regards to price transparency. The Departments, and others, have all stated that there is substantial guidance forthcoming regarding the varying provisions of the No Surprises Act, both before and after Jan. 1, 2022. Although the timeline for implementation and enforcement for some of these requirements was extended in the Department's FAQs, there are still significant requirements under the No Surprises Act (and other recent legislation and regulations) that plans, insurers, and providers will need to prepare for prior to the New Year.

Providers will need to keep a close eye out for additional regulations promulgated from now until the end of the year since they, as of now, will still be required to develop and produce good faith estimates for uninsured patients among other requirements arising from the previous rulemaking, such as reviewing prior agreements with payors for (now prohibited) gag clauses and satisfying the balance billing public disclosure requirements.

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