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EMPLOYEE BENEFITS

Departments Issue Further FAQ Guidance on the No Surprises Act and Transparency in Coverage Final Rules

On August 19, 2022, frequently asked questions related to the Transparency in Coverage Final Rules (TiC Final Rules) and the No Surprises Act (NSA) section of the Consolidated Appropriations Act (CAA) were released jointly by the Departments of Labor, Health and Human Services (HHS) and the Treasury (collectively, the Departments). The FAQs clarify certain items pertaining to balance billing and disclosure requirements under the NSA and the TiC Final Rules, including posting requirements for machine-readable files (MRFs). This release is contained in the publication FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 55 (FAQ - Part 55).

FAQ - Part 55 addresses the NSA and the TiC Final Rules in two separate and distinct sections. Therefore, this article also addresses each of these topics separately beginning with the TiC Final Rules followed by clarifications related to the NSA. For ease of reference, these sections also include important background information into the TiC Final Rules and the NSA.

Transparency in Coverage Rules

Background

The Transparency in Coverage Final Rules (TiC Final Rules) require non-grandfathered group health plans and individual health insurance issuers to disclose information related to the in-network rates for covered items/services, out-of-network allowed amounts and billed charges for items/services and negotiated rates and historical net prices for covered prescription drugs. This information must be contained in separate MRFs and posted on the health plan's public website as of the later of July 1, 2022, or the first day of the plan year beginning on or after January 1, 2022. The requirement to post an MRF containing prescription drug information has been postponed indefinitely.

Under the TiC Final Rules, price comparison information must be made available to participants, beneficiaries and enrollees through an internet-based self-service tool and by telephone (and made available in paper form, upon request). For all plan years beginning on or after January 1, 2023, a list of 500 items and services identified by the Departments in Table 1 of the preamble to the TiC Final Rules must be made available. Thereafter, a list of all covered items and services of a plan/policy must be disclosed through the internet-based self-service tool to participants, beneficiaries and enrollees for all plan years beginning on or after January 1, 2024.

FAQ - Part 55: Clarification on Transparency in Coverage Rules - Machine-Readable Files

FAQ - Part 55 provides plans and issuers greater clarity as to the rules surrounding the requirement to make certain machine-readable files available on a public website. As a reminder, certain machine-readable files related to the plan must be posted on the health plan's public website. This requirement is effective as of the later of July 1, 2022, or the first day of the plan year beginning on or after January 1, 2022.

For self-funded plans, a plan sponsor may satisfy its posting requirement by entering into a written agreement with a service provider (such as a third-party administrator (TPA)) that posts the information on the service provider's/TPA's public website. The ability to delegate the responsibility to a service provider applies regardless of whether the plan sponsor has a public website for its health plan.

Furthermore, FAQ – Part 55 suggests that a link to the service provider's website is required only in very limited situations. If a plan sponsor does maintain a public website for its health plan and the service provider posts an aggregated Allowed Amounts MRF[1], then the health plan must post on its website a link to the location on the service provider's website where the Allowed Amounts MRF is available. The FAQ does not mention any other situation in which a link is required. As a result, it appears plan sponsors are not required to provide a link on their own business website for any MRFs.

Even in those situations where there is an agreement between the plan sponsor/employer and the service provider/TPA relating to the required posting, the plan sponsor/employer is ultimately responsible for its disclosure requirements and may be deemed in violation of these requirements should the service provider/TPA fail to post the balance billing protections disclosure(s) on its public website on behalf of the plan sponsor/employer.

FAQ - Part 55 also addresses when the required internet-based self-service tools contain outdated information, including an item or service code that is no longer valid. In this instance, FAQ - Part 55 states that the Departments will update the 500 items and services quarterly to reflect the retirement of any codes and will provide a reasonable amount of time for plans/issuers to update their internet-based self-service tools.[2]

[1] An out-of-network allowed amount machine-readable file includes:

(A) For each coverage option offered by a group health plan or health insurance issuer, the name and the 14-digit HIOS identifier, or, if the 14-digit HIOS identifier is not available, the 5-digit HIOS identifier, or, if no HIOS identifier is available, the EIN;

(B) A billing code, which in the case of prescription drugs must be an NDC, and a plain language description for each billing code for each covered item or service under each coverage option offered by a plan or issuer; and

(C) Unique out-of-network allowed amounts and billed charges with respect to covered items or services, furnished by out-of-network providers during the 90-day time period that begins 180 days prior to the publication date of the machine-readable file (except that a group health plan or health insurance issuer must omit such data in relation to a particular item or service and provider when compliance with this paragraph (b)(1)(ii)(C) would require the plan or issuer to report payment of out-of-network allowed amounts in connection with fewer than 20 different claims for payments under a single plan or coverage). Consistent with paragraph (c)(3) of this section, nothing in this paragraph (b)(1)(ii)(C) requires the disclosure of information that would violate any applicable health information privacy law. Each unique out-of-network allowed amount must be:

(1) Reflected as a dollar amount, with respect to each covered item or service that is furnished by an out-of-network provider; and

(2) Associated with the NPI, TIN, and Place of Service Code for each out-of-network provider."

[2] The most up-to-date service codes for internet-based self-service tools are provided, here: www.cms.gov/healthplan-price-transparency/resources/500-items-service

No Surprises Act

Background

Pursuant to the NSA, the Departments released interim final rules in July of 2021 that serve to prohibit certain balance billing[3] practices in the following areas:

- Out-of-network emergency services;
- Out-of-network non-emergency services provided during a visit to a participating health care facility; and
- Out-of-network air ambulance services

The interim final rules released in July of 2021 adopted the following calculation methods for certain out-of-network costs associated with the above services. For out-of-network air ambulance services, the cost-sharing amounts must be calculated using the lesser of the billed charge or the qualifying payment amounts (QPA)[4]. For other emergency and non-emergency services, the following methods are used in the calculation of the costs associated with these services:

1) By an applicable All-Payer Model Agreement as governed by the Social Security Act (SSA);

2) If there is no applicable All-Payer Model Agreement, then an amount determined by the applicable state law; or

3) If there is no applicable All-Payer Model Agreement or state law, then the lesser of the billed rate or the QPA.

FAQ - Part 55: Clarification on Application of Certain Provisions within the NSA

No-Network Provider Plans and Closed Network Plans - Application

FAQ - Part 55 addresses many questions under the NSA for group health plans or group/individual health insurance coverage that does not have a provider network. The discussion contained within FAQ - Part 55 clearly states that the rules under the NSA apply regardless of whether the plan/policy provides or does not provide coverage for out-of-network items or services.

The FAQs make clear that the NSA's restrictions on balance billing by nonparticipating[5] providers, emergency facilities, and providers of air ambulance services apply even to health plans/policies that do not have a network of providers (and not only to those plans/policies that have a network of providers/emergency facilities) with respect to emergency services and air ambulance services. This includes health plans that utilize reference-based pricing[6] that do not have a network of providers/emergency facilities. The restrictions would not apply to most non-emergency services because the prohibition on balance billing applies only to non-emergency services provided by a nonparticipating provider during a visit to a ***participating*** health care facility. If there are no participating facilities, that prohibition would be inapplicable.

[3] Balance billing occurs when an out-of-network provider is permitted to bill a participant, beneficiary or enrollee the difference between what that individual's health plan/policy agreed to pay and the full amount charged for a particular service/item. In most instances, this billed amount is greater than the in-network cost for the same service/item, and most likely do not count towards an individual's maximum out-of-pocket (MOOP) limit.

*The prohibition on balance billing under the NSA includes "...prohibition[s] by nonparticipating providers, emergency facilities, and providers of air ambulance services when providing emergency services, certain non-emergency services, or air ambulance services to a participant, beneficiary, or enrollee who is covered under a group health plan or individual health insurance coverage." **FAQ – Part 55, Page 1.***

*[4] QPA is defined as "...the median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty or facility of the same or similar facility type and provided in the geographic region in which the item or service is furnished, increased for inflation. The median contract[ed] rate is determined with respect to all plans of the plan sponsor (or if applicable, administering entity) or all coverage offered by the issuer that are offered in the same insurance market." **FAQ – Part 55, Page 2.***

*When a plan or issuer lacks sufficient information to calculate a median contracted rate (including when there is no network of participating providers/facilities), the plan or issuer must calculate the QPA "using an eligible database, in accordance with the regulations." This method of determining the QPA may not be used by a plan or issuer under any other circumstances. In particular, this method does not apply when "...a plan or issuer has sufficient information to calculate the median of its contracted rates, but payments under its contractual agreements are not on a fee-for-service basis (such as bundled or capitation payments, the plan or issuer is required to...calculate the QPA using underlying fee schedule rates or derived amounts." **FAQ - Part 55, Q3, Footnote 10***

*[5] A nonparticipating provider/emergency facility is any physician or other health care provider/emergency facility that does not have a contractual relationship directly or indirectly with a group health plan or group or individual health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively. **FAQ - Part 55, Q1***

[6] A health plan that utilizes reference-based pricing pays a certain fixed price for each health care service, rather than negotiating a price with each specific provider. Typically, the covered expenses are determined as a percentage of Medicare allowable charges. The health plan pays the fixed price of the service to the provider, and if the provider seeks to further payment for the cost of the service/item, the patient will be billed for the remaining balance.

Plans That Generally Provide No Out-of-Network Coverage – Application

According to FAQ - Part 55, the NSA's protections regarding surprise medical bills apply to a plan even if the health plan generally does not provide coverage for care or items received by providers or facilities that are not part of the plan's network. Accordingly, the NSA's "requirements may result in a plan or coverage providing benefits for out-of-network items and services subject to the surprise billing provisions, even if the plan or coverage otherwise would not provide coverage for these items or services on an out-of-network basis."

Air Ambulance Services - Application

The NSA generally prohibits balance billing and limits cost-sharing for out-of-network air ambulance services. FAQ - Part 55 applies this same rule to jurisdictions outside of the United States, and a plan must establish a "reasonable method" to determine which geographic region applies for the calculation of the QPA of the jurisdiction[7]. However, plans are not required to cover out-of-network non-emergency air ambulance services, regardless of jurisdiction, if they do not cover non-emergency air ambulance services provided by an in-network air ambulance service.

Emergency Services Provided by a Behavioral Health Facility

Emergency services under the NSA refer to services rendered within a hospital/independent freestanding[8] emergency department and include services that are both ancillary and routinely available in an emergency department to evaluate and treat an emergency medical condition[9]. This includes both inpatient and outpatient emergency departments. This also includes both pre- and post-stabilization behavioral health services. Any mental health conditions and substance use disorders that manifest themselves "…by acute symptoms of severity (including severe pain…)" are also subject to the surprise billing protections governed by the NSA, regardless of the license that facility receives or the nature of the emergency services that facility is licensed to provide.

[7] ***Example:*** *A nonparticipating provider of air ambulance services is dispatched from Florida to pick up an individual experiencing a medical emergency in the Bahamas and transports the individual back to a hospital in the United States, entering the United States through the Miami-Fort Lauderdale-West Palm Beach MSA. The nonparticipating provider of air ambulance services submits a claim [for its services] to the individual's plan or issuer. The plan or issuer determines that the air ambulance services are a covered benefit under the terms of the individual's coverage. The plan or issuer could reasonably calculate the QPA for the air ambulance services using the geographic region that corresponds to the United States border point of entry, which in this case would be the region consisting of all MSAs in Florida, provided the plan or issuer has sufficient information to calculate a median contracted rate for that region.* ***FAQ - Part 55, Q9***

[8] *A freestanding emergency department is defined as "…any health care facility that is geographically separate and distinct from a hospital and licensed by a state to provide emergency services (as defined in the July 2021 interim final rules), with respect to an emergency medical condition."* ***FAQ - Part 55, Q9***

[9] *Emergency medical condition is defined as "…a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in section 1867(e)(1)(A)(i)-(iii) of the SSA." (i.e., "…the absence of immediate medical attention could reasonably be expected to result in" serious jeopardy to the health of the individual, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or that may pose a threat to the health or safety of pregnant woman or unborn child.)* ***FAQ - Part 55, Q9***

Balance Billing Protections Disclosure

Under the NSA, plans and issuers must provide certain balance billing protection disclosure(s) to participants, beneficiaries and enrollees. This information must be made publicly available, posted on a public website of the plan/issuer, and included within each explanation of benefits for the item or service[10]. This requirement is applicable for all plan years beginning on or after January 1, 2022.

If a plan sponsor does not have a public website for its health plan, a plan sponsor may satisfy its posting requirement by entering into a written agreement with a health insurance carrier or a third-party administrator (TPA) that posts the information on the carrier's/TPA's public website that is usually accessible by participants, beneficiaries and enrollees of the plan. FAQ - Part 55 clarifies that a plan sponsor/employer is not considered to have a public website if the only website a plan sponsor/employer has is for business purposes and does not host a specific website for the group health plan it sponsors. Therefore, if a plan sponsor/employer merely maintains a public website for its business but no public website for the group health plan, the plan sponsor/employer need not create a public website for the health plan to satisfy its posting requirement so long as it has entered into a written agreement with the carrier/TPA to publish this information on the carrier/TPA website on behalf of the plan sponsor/employer. Despite the existence of such an agreement between the plan sponsor/employer and the insurance carrier/TPA, if the insurance carrier/TPA fails to abide by its agreement to post the balance billing protections disclosure(s) on its public website on behalf of the plan sponsor/employer, the plan sponsor/employer is ultimately in violation of the disclosure requirement.

A plan sponsor is not only responsible for the disclosure of the federal out-of-network balance billing protections but also must disclose any out-of-network balance billing protections provided for under state law. FAQ – Part 55 provides that plan sponsors/employers need only disclose state-based information "applicable" to that plan sponsor/employer. Therefore, if the health plan is a self-funded plan subject to ERISA or the state balance billing protections do not apply to the plan sponsor/employer that has insurance contracts issued outside of that state, a plan sponsor may not be required to disclose those state-based balance billing protections to its participants, beneficiaries and enrollees.

Model Notice of Protections Against Balance Billing

The Departments consider a plan sponsor/issuer that provides the Model Notice of Protections Against Balance Billing in accordance with the accompanying instructions as acting in good faith in meeting its obligations under the NSA and the interim final rules. Two versions of the Model Notice of Protections Against Balance Billing[11] (Model Notices) were included in FAQ – Part 55. A plan sponsor/issuer is considered in good faith compliance under the NSA rules so long as a plan sponsor/issuer provides either version of the Model Notices for plan years beginning on or after January 1, 2022, and before January 1, 2023. Thereafter, the Departments will only consider a plan sponsor/issuer to be acting in good faith with the NSA/interim final rules if it provides the revised version of the Model Notice to participants, beneficiaries and enrollees for plan or policy years beginning on or after January 1, 2023.

FAQ – Part 55: Conclusion

FAQ - Part 55 provides guidance to plan sponsors/carriers/TPAs regarding provisions set forth in both the NSA and its related interim final rules. In addition, FAQ - Part 55 provides further insight into the rules surrounding the TiC Final Rules. Plan sponsors/employers should work closely with their carriers/TPAs in administering these rules and should work with their health plan's legal counsel to help ensure full compliance under both rules.

*[10] The elements of the disclosure must include "(1) the requirements under those sections, as applicable; (2) the requirements and prohibitions applied under sections 2799B-1 and 2799B-2 of the PHS Act (relating to the prohibitions against balance billing for emergency and non-emergency services in certain circumstances); (3) other applicable state laws on out-of-network balance billing; and (4) contacting appropriate state and Federal agencies if an individual believes the provider or facility has violated the prohibition against balance billing." **FAQ - Part 55, Q10***

*[11] This Model Notice that may be used only for plan years beginning on or after January 1, 2022 and before January 1, 2023: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf **Pages 8-9***

*This Revised Model Notice may be used for plan years beginning on or after January 1, 2022, and on or after January 1, 2023: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf **Pages 15-16***

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