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New FAQ Addresses NSA and TiC Rules

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The Departments of Labor, Health and Human Services and the Treasury (collectively, "the Departments") issued FAQ Part 55, providing guidance as it relates to certain aspects of the No Surprises Act ("NSA") and the Transparency in Coverage ("TiC") final regulations. FAQ 55 includes 23 questions and answers. The guidance is lengthy and very detailed. Below you will find some of the key highlights of the guidance.

No Surprises Act

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

- Emergency services;
- Non-emergency services delivered by OON providers at in-network (participating) facilities; and
- OON air ambulance services.

The FAQ:

The NSA provides protection to covered members as it relates to out-of-network ("OON") cost-sharing and balance billing with respect to the following services:

- Addresses how the NSA applies to plans without a network of providers, closed network plans and air ambulances services;
- Confirms the NSA applies to emergency services furnished in behavioral health crisis facilities;
- Clarifies the disclosure requirements and provides a revised model disclosure notice for group health plans; and
- Further explains calculating the qualifying payment amount ("QPA") and answers various questions related to the federal independent dispute resolution ("IDR") process.

No Network Plans

In a plan that does not have a network of providers (e.g., reference-based pricing plans):

- The surprise billing protections apply to OON emergency services and OON air ambulance services. However, the protections with respect to non-emergency services provided by OON providers at in-network facilities would never be triggered if a plan does not have a network of participating facilities.

- Cost-sharing for OON items and services subject to the NSA is based on the lesser of the billed charge or the QPA. When a plan does not have sufficient information to calculate a median contracted rate, for example because the plan does not have a network of participating providers for the items or services involved, the QPA should be calculated using an eligible data base in accordance with the regulations.

- Out-of-pocket spending incurred by a participant for emergency services should be counted against the maximum out-of-pocket ("MOOP") spending with respect to providers who do not accept the reference price. Under the NSA, this definition is expanded to include post-stabilization services that are emergency services.

Closed Network Plans

The NSA protections for emergency services, non-emergency services furnished by an OON provider at an in-network facility, and air ambulance services apply if those services are otherwise covered under the plan, even if the plan does not provide coverage OON.

This requirement may result in the plan providing benefits for OON items and services subject to the NSA even if the plan would not otherwise cover these items and service on an OON basis.

Disclosures for Protection Against Balance Billing

Under the NSA, a group health plan and carrier must make a disclosure of the protections under the NSA publicly available, posted on a public website of the plan or carrier and included on each explanation of benefits ("EOB") for NSA claims.

The FAQ:

- Clarifies that if a group health plan does not have a website, the plan may satisfy the public posting requirement by entering into a written agreement with a carrier or TPA to post the information on its public website where information is normally made available to participants. This would apply in instances where the plan sponsor (for example, an employer) may maintain a public website, but the group health plan sponsored by the employer does not.

- Confirms that plans are not required to provide information on all state balance billing laws in the required disclosure. Rather plans are only required to provide information on applicable state laws regarding OON balance billing. If a

plan is a self-funded ERISA plan, generally state balance billing laws are not applicable; therefore, a plan does not need to include state balance billing information. However,if a self-funded plan has voluntarily "opted in" to a state balance billing law, the plan must disclose that information.

The model NSA disclosure has been updated for use by group health plans and carriers for plan years beginning on or after January 1, 2023. Before this date, a plan may use either the original model notice or the updated version. For the revised instructions and notice, visit: https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf (starts on page 14).

Calculating the Qualifying Payment Amount

The FAQ provides additional clarification on calculating the QPA by provider specialty and permits self-funded health plans with multiple benefit options administered by different TPAs to calculate median contracted rates separate for those benefit packages administered by the TPA (instead of having to aggregate the rate across separate benefit package options administered by separate TPAs).

Federal IDR Process

The FAQ offers further clarification on the federal IDR process to ensure billing disputes are resolved in a timely manner. Among other requirements, the FAQs address timeframes and additional disclosures that must be satisfied when the plan makes an initial payment or send notice of a denial of payment to a provider or facility, and the process for initiating an open negotiation period that must precede any initiation of the federal IDR process.

Transparency in Coverage

The final TiC rule requires group health plans and carriers make public three machine-readable files ("MRFs") disclosing:

1. In-network rates,
2. OON allowed amounts and billed charges, and
3. Negotiated rates and historical net prices for covered prescription drugs.

With respect to (1) and (2), the requirement to post MRFs took effect July 1, 2022 (for plan years that began between January 1, 2022 and July 1, 2022) and, for plan years that begin after July 1, 2022, the file must be posted in the month the plan year begins. These files must be updated monthly. The MRF related to prescription drugs is not being enforced pending further guidance.

In addition, for plan years beginning on or after January 1, 2023, group health plans and carriers must disclose cost sharing information with respect to 500 identified items and services in advance of receiving care. Full compliance is required for plan years beginning on or after January 1, 2024.

TiC – Machine-Readable Files

There was some confusion with respect to the website posting requirement under the regulations. The FAQ confirms:

- If a group health plan does not have its own public website, nothing in the final rules requires the plan to create its own website for the purposes of providing a link to a location where the MRFs are publicly available.
- A plan may satisfy the disclosure requirement by entering into a written agreement under which a TPA posts the machine-readable files on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable.

TiC – Cost-Sharing Disclosure

The FAQ provides a link to the list of the 500 items and services that must be included in the first phase of implementation of the internet-based self-service tool: www.cms.gov/healthplan-price-transparency/resources/500-items-services.

The Departments will update the list quarterly to reflect changes (including the retirement of any codes) and provide a reasonable period of time for plan and carriers to update their tools to reflect current codes.

Plans and carriers should refer to this webpage for the most up-to-date list of codes to comply with the requirements regarding the self-service tool for plan years beginning on or after January 1, 2023.

Employer Action

The guidance provides helpful clarification. Many aspects of the NSA and TiC rules are functions of plan administration and claims payment; support from carriers and third-party administrators ("TPAs") is essential for compliance.

For fully insured plans, these requirements should be handled by the carrier.

For a self-funded plan (including level-funded), the plan is ultimately responsible for compliance and should work with third party administrators to ensure the plan is administered in accordance with the NSA and TiC rules.