SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Self-Insured Health Fund Clients

From: Slevin & Hart, P.C.

Date: September 20, 2021

Re: The No Surprises Act – Interim Final Rule; FAQs on Consolidated Appropriations Act and Transparency in Coverage Final Rule

---

This follows our memoranda dated February 26, 2021 regarding the Transparency in Coverage Final Rule ("Transparency Rule"), March 3, 2021 regarding the No Surprises Act (the "Act"), that was enacted in December 2020 as part of the Consolidated Appropriations Act of 2021 ("CAA"), and March 9, 2021 regarding additional provisions of the CAA.

On July 1, 2021, the Departments of the Treasury, Labor, and Health and Human Services (the "Departments") jointly issued an Interim Final Rule ("Rule") to implement certain provisions of the Act. The Rule addresses various aspects of the prohibition against balance billing participants for certain out-of-network services, including the methodology for calculating participant cost sharing amounts and certain notice requirements. The Rule did not address many other aspects of the Act, but the preamble to the Rule advises that, consistent with the deadline to issue regulations imposed by the Act, regulations regarding the Independent Dispute Resolution ("IDR") process will be issued no later than December 27, 2021.

In follow up to the Rule, on August 20, 2021, the Departments issued Frequently Asked Questions ("FAQs") on provisions of the Transparency Rule and provisions of the CAA not addressed in the Rule. As discussed in more detail below, the FAQs delay the enforcement date for the machine-readable file requirements in the Transparency Rule and for certain provisions of the CAA to a later date or until guidance is issued, and for other CAA provisions, advise plans to implement "good faith compliance" until guidance is issued.

Background on the Act and the Transparency Rule

As noted in our March 3rd memorandum, the Act applies to plans regardless of the plan's grandfathered status under the Affordable Care Act ("ACA") but does not apply to "excepted benefits" under ERISA or retiree-only plans. The Act's requirements are generally effective for

plan years commencing on or after January 1, 2022 (except to the extent now delayed under the FAQs as noted below).

The Act generally prohibits patients from being balanced billed for the following four types of services ("Covered Services"): (1) out-of-network emergency services; (2) out-of-network air ambulance services; (3) non-emergency ancillary services (such as anesthesiology, pathology, radiology and diagnostic services) performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-emergency services performed at in-network facilities when the provider fails to give the appropriate notice to, and does not obtain consent from, a patient. These Covered Services only have to be covered if these services are provided on an in-network basis.

These Covered Services are also subject to the following coverage mandates: (1) participant cost sharing cannot exceed the cost sharing applied to equivalent in-network services (for air ambulance services, the out-of-network cost sharing must be the same as the in-network services' cost sharing); (2) all participant cost sharing must be counted towards the plan's in-network deductible and in-network out-of-pocket maximum in the same manner as if the service was provided in-network; (3) the participant cost sharing amounts is determined as if the total amount paid to the provider is based on a "Recognized Amount" (to be described in Section I.F below); and (4) a final plan payment to the provider must equal the amount determined after the completion of the IDR process (if invoked) minus the participant's cost sharing amount determined by the Rule and the plan's initial payment, or the initial payment amount if the IDR process is not invoked. In addition, no prior authorization, and no administrative or other limitation that is more restrictive than what is applied to equivalent in-network emergency services, may be applied to out-of-network emergency services.

As noted in our February 26th memorandum, the Transparency Rule, which only applies to non-grandfathered plans, had an initial effective date for plan years commencing on or after January 1, 2022 for the machine-readable file requirements (now delayed under the FAQs, as noted below), and an effective date for plan years commencing on or after January 1, 2023 and January 1, 2024 for the price comparison tool requirements (which have not been delayed).

Summary of Rule and FAQs/Actions Needed

- The Act requires plans to provide Covered Services on an out-of-network basis if the plan provides those services on an in-network basis. Therefore, plans should identify whether any Covered Services are currently covered on an in-network basis only and if so, evaluate the cost implications with the plan's consultant for providing coverage on an out-of-network basis consistent with the coverage mandates.

- Plan documents, including SBCs and SPDs, will have to be amended to apply the coverage mandates to Covered Services consistent with the Act and the Rule. We suggest that plan documents be amended to state that such coverage amounts will be determined "based on applicable federal law."

- The Rule clarifies that, even if an individual has not satisfied the plan's deductible yet, the amount of cost sharing payable by an individual for a Covered Service cannot exceed a

percentage of the "Recognized Amount" (described further in section I.F.) Plan documents and SPDs should be amended accordingly.

- The Rule clarifies that the definition of "emergency services" is expanded from how it was defined under the ACA's Emergency Coverage Mandate to require that: (1) general exclusions be applied to emergency services only to the extent the exclusions are not inconsistent with the Act's requirements; (2) emergency services provided in an "independent freestanding emergency center" be covered; (3) stabilization services provided after inpatient admissions be covered; (4) post-stabilization services that are part of the same emergency visit be covered, unless four requirements are met (one of which is the Notice/Consent Requirements, described below); and (5) services cannot be denied as non-emergency solely on the basis of diagnosis codes.

  Consequently, plans will need to:

  - review, and modify if necessary, the plan document's definition of "emergency services" to be consistent with the Act's expanded definition;
  - amend the plan documents' general exclusions to make clear that such exclusions may be applied only to the extent not inconsistent with the Act's mandate to cover emergency services; and
  - review their contracts with any third-party claims administration vendor to confirm that they require the vendor to comply with applicable law, including these new standards, when adjudicating claims for emergency services.

- The Rule states that while any cost sharing for Covered Services is required to be applied to the in-network deductible and out-of-pocket maximum, it is not required to apply to the out-of-network deductible and out-of-pocket maximum. Therefore, even though the Covered Service will be out-of-network, the participant cost sharing for that Covered Service does not have to apply to the out-of-network deductible or out-of-pocket maximum. If the plan follows this approach, plan documents will have to be amended to make clear that an out-of-network claim for Covered Services will not apply towards the plan's out-of-network deductible and out-of-pocket maximum.

- The Rule clarifies that, for non-emergency, non-ancillary services performed at in-network facilities where the Notice/Consent Requirements described below could apply to waive the Act's protections, providers are required to provide the plan with documents demonstrating that the Notice/Consent Requirements have been satisfied as part of a claims submission. If these documents are not provided, the Rule also requires plans to assume that the Notice/Consent Requirements have not been met and the Act's protections will apply to such a claim. If the claims submission is silent on this issue, it appears reasonable for the plan to ask the provider/facility to confirm if the Notice/Consent Requirements have been satisfied. But if no response is provided, it would appear that the plan must operate on the assumption that the Notice/Consent Requirements have not been satisfied and process the claim consistent with the Act's requirements.

- The Act requires that the amount of participant cost sharing must be based on a "Recognized Amount." The Rule further clarifies this requirement by: (1) extending this

cost sharing requirement to air ambulance services; (2) confirming that the "Recognized Amount" is not required to be used for anything other than determining participant cost sharing (i.e., it does not have to be used when determining the initial payment to providers and facilities); and (3) explaining how the Qualifying Payment Amount ("QPA"), which is the "Recognized Amount" when there is no controlling state law mandating a particular payment amount, is determined.

Consequently, plans remain free to maintain their current methodology for determining the initial payment for out-of-network providers/facilities for Covered Services, provided that they use the QPA methodology for determining the participant cost sharing. Alternatively, plans may want to discuss with the benefits consultant and/or the third-party claims administration vendor whether to use the QPA methodology for both purposes.

- Plans also should discuss with the consultant which methodology to use for determining the QPA. The Rule permits a plan to use either the rates at which the plan has paid an in-network provider historically for that service or an aggregate of the in-network rates of all plans administered by the plan's PPO network provider. If the plan's PPO network vendor provides the QPA, the vendor may insist on one approach or the other, so that the vendor can implement the same approach across all of its PPO clients. This should be reflected in the vendor's contract.

- It is anticipated that all plans will have to rely on the third-party claims administration vendor or PPO network vendor, to determine the QPA since it will be based in part on the in-network rates that have historically been used by the plan. The Rule clarifies that plans are required to provide certain specific information related to the QPA determination for each Covered Service to providers and facilities. Therefore, plans should seek to amend their PPO network and/or claims administration vendor contracts to require that all calculations related to the QPA, and all required notice and disclosures related to the QPA, will be the responsibility of the vendor and that the vendor will indemnify the plan for any potential losses resulting from the vendor's failure to follow the Act's QPA requirements. (The $100 per day excise tax penalty under section 4980D of the Code applies generally to failures to comply with the Act's requirements.)

- The Rule allows plans up to 30 days to adjudicate a claim for a Covered Service upon receiving all information necessary to adjudicate the claim (referred to as a "Clean Claim" under the Act). Therefore, plans may want to amend their plan documents to allow for additional time to adjudicate claims for Covered Services in circumstances where previously the DOL's claims procedures would have required plans to adjudicate the claims within 15 days of receiving any requested information necessary to "perfect" a claim.

- The Act requires that plans make publicly available, post on the plan's public website and include in EOBs issued for Covered Services (except for air ambulance claims) a disclosure regarding the prohibition against balance billing. Plans should use the model notice provided in the Rule to satisfy the requirement and post it on the plan's website. We view posting on the website to also satisfy the requirement that the disclosure be made publicly available. If the plan does not have a website, in the absence of specific guidance

mandating the plan have a website, plans should circulate the notice to all covered individuals under the plan to establish good faith compliance. If the EOB is prepared by a third party claims administration vendor, plans should confirm that the vendor will update the EOB to include the required language.

- **Delayed Effective/Enforcement Dates and other Guidance under the FAQs**

  The FAQs announce delayed effective/enforcement dates for the following provisions of the CAA and Transparency Rule:

  - the Transparency Rule requirement for non-grandfathered plans to publish in-network rates and out-of-network allowed amounts and billed charges is delayed **until July 1, 2022** without regard to when the plan year began;

  - the Transparency Rule requirement for non-grandfathered plans to publish a prescription drug pricing file, and the CAA's reporting requirement on pharmacy benefits and drug costs requirement, are delayed **until further rulemaking is issued**;

  - the Act's price comparison tool requirement is delayed **until plan years beginning on or after January 1, 2023**; and

  - the CAA's requirement for providers and facilities to provide a good faith estimate of expected charges for an individual's scheduled item or service to a plan, and the plan's corresponding requirement to provide an advanced EOBs with the good faith estimate, are delayed **until further rulemaking is issued**.

- The FAQs state that the Departments expect to issue guidance on other provisions of the Act, but not prior to their original 2022 effective date, including on: (1) ID card requirements; (2) provider directory requirements; and (3) continuity of care requirements. Until this guidance is issued, the Departments expect plans to implement these provisions using a good faith, reasonable interpretation of the Act. Plans will have a prospective effective date to comply with any such future rulemaking. The FAQs suggest that good faith compliance for these requirements would be as follows:

  - ID Cards: The FAQs make clear that all physical or electronic cards must list at least the main deductible and out-of-pocket maximum limitations under the plan, but do not need to list every deductible and out-of-pocket maximum. However, the FAQs provide no clear guidance about whether plans are required to issue new physical cards or whether updating electronic cards is sufficient. Therefore, if plans prefer not to reissue physical cards to all participants as of the effective date of this requirement, or the vendor is unwilling to issue new physical cards as of that date, plans should discuss what approach it would like to take with respect to issuing new cards to participants, especially if those participants are not able to access electronic cards.

- Provider Directory: A plan will not be treated as violating the provider directory requirements as long as it provides for in-network cost sharing (counted towards any in-network deductible or out-of-pocket maximum) for an individual who receives out-of-network items or services after being provided inaccurate information by the plan that stated the provider or facility was in-network under a provider directory or a response protocol. Therefore, plans may want to work with their PPO network vendor to develop a process for updating provider directories and protocols for responding to participant inquiries regarding a provider's status to avoid this result.

- Continuity of Care: Since the FAQs provide no guidance, plans should continue to work with the vendor to determine how to implement this requirement.

- The Departments do not intend to issue regulations addressing the CAA's prohibition on gag clauses on price and quality data but will issue guidance on how to address the requirement that plans submit an annual attestation confirming compliance with the prohibition, which the FAQs anticipate will not be required until 2022 at the earliest. Therefore, in the absence of additional guidance, we continue to recommend the same approach taken in our March 9th memorandum and any applicable new provider contracts or contract renewals that the plan enters into on or after December 27, 2020 should comply with the prohibition on gag clauses.

I. Coverage Requirements Applicable to Covered Services

A. Scope of Coverage Mandates for Covered Services

The Rule confirms that "excepted benefits" under ERISA and retiree-only plans are not subject to the Act's requirements. Common excepted benefits under ERISA include stand-alone dental and vision benefits, which include self-insured dental or vision benefits when claims are administered by a third-party administrator under a contract separate from the administration of medical benefits. This means that, if the plan has a particular excepted benefit such as a stand-alone dental benefit, that benefit will not be subject to the Act's requirements. This will not impact, for example, the hospital/medical benefits under the plan being subject to the Act.

B. Cost Sharing Limitations Will Apply Even if an Individual's Deductible Has Not Been Met

The Act generally provides that the amount a plan must pay for a Covered Service is the difference between the cost sharing amount that the individual is required to pay (described in Section I.F. below) and the total amount ultimately determined to be owed for the claim under the IDR process. The preamble to the Rule clarifies that, if an individual has not yet satisfied his or her in-network deductible, plans still must pay any amount in excess of the participant's cost sharing amount for a Covered Service owed under the Act. Plan documents will need to be amended to reflect this rule.

C. Cost Sharing for Covered Services Applies Only to In-Network Deductibles and In-Network Out-of-Pocket Maximums

As discussed in our March 3rd memorandum, the Act requires that any cost sharing amounts paid by participants for Covered Services be applied towards any in-network deductibles and in-network out-of-pocket maximums under the plan in the same manner as if the Covered Service was performed in-network. The Act does not address whether these cost sharing amounts must also apply towards out-of-network deductibles and out-of-pocket maximums. The Rule clarifies that cost sharing amounts paid by participants for Covered Services can, but are not required to, count towards any out-of-network deductibles and out-of-network out-of-pocket maximums under the plan. If the Trustees decide to not apply the cost sharing for a Covered Service to an out-of-network out-of-pocket maximum, plan documents should be amended accordingly.

The Rule also adds a reference that the cost sharing must be applied to satisfy the ACA's out-of-pocket maximum requirements but only "as applicable." Generally, for non-grandfathered plans, the ACA limits an individual's out of-pocket expenses for "essential benefits," which are determined based on the state benchmark plan selected by the plan. Therefore, to the extent a plan has an in-network out-of-pocket maximum that is limited to ACA's "essential benefits," the ambiguity created by the new reference makes it unclear whether for a Covered Service that is not considered an "essential benefit" (for example, air ambulance services), the cost sharing would have to apply to that plan's in-network out-of-pocket maximum as a result of the Act. We hope future guidance will clarify this point, but in the absence of specific guidance, it appears reasonable for non-grandfathered plans with an in-network out-of-pocket maximum that is limited to ACA "essential benefits" to continue excluding Covered Services that are not essential benefits from the out-of-pocket maximum.

D. Emergency Services

1. *Sunsetting of ACA's Emergency Coverage Mandate*

The ACA requires non-grandfathered plans to cover out-of-network emergency services at a rate (minus any copayment or coinsurance imposed) that is not less than the greater of: (1) the amount negotiated with in-network providers for the emergency service furnished; (2) the amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services; or (3) the amount that would be paid under Medicare for the emergency service ("ACA Emergency Coverage Mandate"). In order to avoid conflicting obligations with respect to emergency services under the ACA and the Act, the Rule clarifies that the ACA Emergency Coverage Mandate is repealed when the Act becomes effective. Therefore, beginning with the 2022 Plan Year, plans are no longer required to pay for emergency services at this "greatest of three" rate. Instead, all plans, including those still grandfathered under the ACA, must cover out-of-network emergency services consistent with the Act. Importantly, for plans that are still grandfathered under the ACA, this is the first time federal law has dictated how emergency services must be covered under a plan.

2. *Definition of Emergency Services*

There are a number of changes to the definition of "emergency services" compared to how the ACA Emergency Coverage Mandate defined this term. Plan documents will need to be

amended to reflect a definition of "emergency services" that is consistent with this expanded definition.

First, the Rule appears to limit the exclusions that can be applied for emergency services. Specifically, the Act, like the ACA Emergency Coverage Mandate before it, stated that emergency services must be provided "without regard to any other term or condition of the coverage, other than the exclusion or coordination of benefits…" However, the Rule clarifies that such an exclusion can be applied only "to the extent not inconsistent with benefits for an emergency medical condition" as defined by the Act. To explain the application of this requirement, the preamble to the Rule states that it would violate the Act for a plan to deny coverage for a dependent woman who is pregnant and suffers an emergency with respect to her pregnancy based on a general plan exclusion for dependent maternity care. Therefore, it is not clear the extent to which general plan exclusions can continue to be applied to emergency services. Until the issue is further clarified, we recommend that plan documents be amended to state that general exclusions may be applied only to the extent not inconsistent with the Act's mandate to cover emergency services.

Second, the provisions of the Act related to emergency services now apply to services performed in an independent, freestanding, emergency center, instead of only to services performed at the emergency department of a hospital, as provided under the ACA Emergency Coverage Mandate. The Rule defines an independent, freestanding, emergency center as any facility that is geographically separate and distinct from a hospital that is licensed under state law to provide emergency services, regardless of how the facility is classified, which the preamble to the Rule indicates could include urgent care centers. Therefore, for example, if a plan receives a claim for emergency services from an urgent care center licensed under state law to provide such services, the claim must be processed consistent with the Act's requirements, and the plan documents should be amended accordingly, if necessary.

Third, under the Act, emergency services also include any medical examination and treatment necessary to stabilize the patient "regardless of the department of the hospital in which such further treatment is furnished." Prior to the Act, the ACA Emergency Coverage Mandate was interpreted to apply only to treatment provided in an emergency setting, meaning that the ACA Emergency Coverage Mandate no longer applied after a patient left the emergency room and was admitted inpatient, even if stabilization services were still being performed while an inpatient. Now, stabilization services performed after an inpatient admission will be subject to the Act's requirements.

Finally, the Rule also clarifies that the Act has broadened "emergency services" to include post-stabilization services rendered to a patient admitted through an emergency department or an independent, freestanding, emergency center, and generally would include all services that are part of the same visit in which the emergency medical condition was treated unless the following four requirements are met: (1) the attending physician determines the patient is able to travel using nonmedical or nonemergency medical transportation to an available participating provider or facility located within a reasonable distance, taking into account the individual's medical condition; (2) the provider or facility furnishing the additional items and services satisfies the Notice/Consent Requirements; (3) the patient (or an authorized representative of such individual) is in a condition to receive the notice and provide informed consent; and (4) the provider or facility satisfies any additional requirements or prohibitions required by state law.

3. *Adjudication of Claims for Emergency Services*

Like the ACA, the Act defines "emergency services" to include services in response to anything a prudent layperson possessing an average knowledge of health and medicine could reasonably expect would put the patient's health in serious jeopardy, absent immediate care. The Rule clarifies that a plan cannot rely solely on diagnosis codes to determine whether a situation is an emergency. For example, a plan cannot deny coverage for services rendered to an individual complaining of chest pains because he did not suffer a heart attack, but rather was diagnosed with acid reflux. The preamble to the Rule makes clear that it is not sufficient for plans to handle this on an appeal basis. Therefore, plans will need to adjudicate emergency claims by reviewing the facts and circumstances of each case. Plans that have a third-party claims administration vendor processing medical claims should consider revising the contract as needed so the vendor is responsible for applying this standard when adjudicating claims.

E. Non-Emergency, Non-Ancillary Services Performed by Out-of-Network Providers at In-Network Health Care Facilities.

As noted above, Covered Services include non-emergency, non-ancillary services performed by out-of-network providers at in-network health care facilities (defined in the Act as a hospital, a hospital outpatient department, a critical access hospital or an ambulatory surgical center) if the patient did not receive notice from the facility/provider performing the service or did not give informed consent for treatment ("Notice/Consent Requirements"). This requirement means that, for example, if a facility or the out-of-network provider itself does not provide the appropriate notice that a provider is out-of-network, the provider cannot balance bill the patient and the plan must cover those services consistent with the Act.

To assist with administering this requirement, the Rule provides detailed criteria to out-of-network providers and facilities that, among other things, indicate what specific disclosures must be part of any notice given and consent obtained from a patient in order to satisfy the Notice/Consent Requirements. These disclosures are focused primarily on telling the patient of the Act's protections that are being waived by giving informed consent. The Rule requires that providers notify plans each time they furnish a non-emergency, non-ancillary service at an in-network health care facility and "if applicable" provide the plan a copy of the documents demonstrating that the patient received the required notice and consented to the service. A plan is permitted to rely on the documentation given by a provider/facility to establish compliance with the Notice/Consent Requirements unless the plan knows or reasonably should know that the notice and/or consent were not proper. The Rule states that if the documents are not provided, plans must treat the claim as if the Act's protections apply, which means that the participant cannot be balanced billed, participant cost sharing must be based on the QPA, the mandatory 30-day negotiation period is applicable and the provider can request IDR. (These same requirements also apply to out-of-network facilities providing post-stabilization emergency services to satisfy the Notice/Consent Requirements for such services to be exempt from the Act's protections, as described in Section I.D.2 of this memorandum.)

If the provider or facility does not indicate on the claim whether the Notice/Consent Requirements have been satisfied, the Rule does not provide clear guidance on whether a plan

must treat silence on the initial submission as meaning that the Notice/Consent Requirements have not been met. Given this lack of clarity, we think it would be reasonable to treat provider/facility silence on this issue as a basis to trigger a follow up inquiry from the plan to the provider or facility, consistent with the DOL's claims and appeals procedures, and for the claim to be treated as incomplete. However, if the provider does not respond within the periods required by the DOL's claims and appeals procedures (generally 45 days), and the plan has all other information needed to adjudicate the claim, plans appear to be required to process the claim as if the Act's protections apply. Hopefully, future guidance will clarify this issue.

The other concern for plans is that, if a provider or facility simply fails to give notice and/or does not attempt to obtain consent, the Rule appears to require plans to administer the claim consistent with the Act's requirements, even if the provider or facility could have avoided that result. This creates a situation in which, based on the outcome of the IDR process, a plan may pay more for a claim than it would otherwise have paid if the provider or facility satisfied the Notice/Consent Requirements. However, this also creates the risk to the provider or facility of only receiving the plan's initial payment amount without the ability to balance bill a participant if the provider is unsuccessful in the IDR process. Nonetheless, plans should consider discussing with their PPO network vendor whether it has, or intends to include, language in their provider contracts with in-network facilities to address the Notice/Consent Requirements.

F. Rules on Calculating and Disclosing the "Qualifying Payment Amount" for Cost Sharing Purposes

The Act requires that a participant's cost sharing amount for Covered Services be calculated based on the "Recognized Amount." The Recognized Amount is the amount payable under state law pricing rules or, if no state law pricing rules apply because the state in which the plan is located does not have a pricing law or the state law is preempted, the Recognized Amount is the QPA. However, if a self-insured plan has voluntarily opted in to a state medical pricing law to which a Covered Service is subject, the state law payment rules will apply for purposes of determining the applicable Recognized Amount, provided the plan notifies its participants that that it has chosen to opt in to the state law and provides a general description of the items and services covered by that law.

As an initial matter, the Rule makes clear that if the actual billed charges are less than the Recognized Amount/QPA, participant cost sharing must be based on the actual billed charges. The Rule also makes clear that the Recognized Amount/QPA only applies for purposes of determining the participant's cost sharing and is not required to be used for determining the plan's initial payment to the provider. Therefore, plans can continue to use the current methodology to determine the plan's initial payment for a Covered Service. Plans may want to discuss with their consultant and/or their claims administrator if there is an advantage to using the QPA methodology for both purposes for administrative convenience.

As required by the Act, the Rule describes the methodology for calculating the QPA, which is generally required to be based on the median of the in-network rates payable for a particular service as of a particular date, as determined by the Rule. We anticipate that, since the QPA is based on in-network rates and those rates are typically set for plans by their PPO network and/or claims administration vendors, plans will simply rely on those vendors to determine and provide

the correct QPA for each claim. Therefore, plans should seek to contractually obligate the applicable vendor(s) to be responsible to administer the QPA consistent with the Rule. We note that the preamble to the Rule specifically requests comments on whether plans have the ability to monitor PPO network vendors to confirm that QPAs are being determined consistent with the Rule. This suggests that plans are ultimately responsible for confirming that QPAs are properly calculated.

However, there is a threshold question as to the exact universe of in-network rates to be used for determining the QPA that should be addressed with the PPO network and/or claims administration vendor. The Rule allows the plan to rely on either the plan's historical rate paid to an in-network provider (as determined by specific provisions in the Rule) or an aggregate of the in-network rates of all plans administered by the plan's PPO network vendor. First, plans should discuss with their consultant which option for calculating the Recognized Amount/QPA would be most advantageous for the plan. Once that is selected, plans should memorialize this decision in the contract with the PPO network and/or claims administration vendor. We note that the PPO network and/or claims administration vendor may insist on using one method or the other for plans they administer for administrative convenience and make this a condition of providing these services on the plan's behalf.

The plan is also responsible for disclosing various aspects of the QPA determination to providers and facilities as part of claims adjudication. The Rule requires plans to notify the provider or facility when they make payment on a claim for a Covered Service (or issue a denial if the claim is not covered) of the following information, in writing:

- the QPA for each item or service that is part of the claim;
- a statement certifying that the plan determined the QPA applies for purposes of the Recognized Amount and it was determined in accordance with the Rule;
- a statement that the provider or facility may initiate a 30-day negotiation period if it is dissatisfied with the amount paid by the plan;
- a statement that the provider has the right to request IDR within four days after the 30-day negotiation period ends; and
- contact information for the appropriate person or office to initiate the negotiation.

Upon request by the provider or facility, the plan must provide certain specific information, including: (1) how the QPA was determined, including whether the in-network rates used to calculate the QPA include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments; (2) whether the plan used an "eligible database" to determine the QPA and information to identify which database was used; and (3) if a related service code was used to determine the QPA because an item or service was billed under a new service code, information necessary to identify the related service code. (A new service code can occur when service codes are substantially revised.)

If the plan does not have sufficient information to calculate the in-network rate that makes up the QPA determination in accordance with the Rule, the Rule requires plans to use an "eligible database." An eligible database means a state all-payer claims database or a third-party database that meets the criteria listed in the Rule. The plan must also provide, upon request, an explanation

of payment adjustments for the items and services that were excluded from the calculation, for example a modifier code.

Given the extent of these notice requirements, plans also should seek to amend their contracts with PPO network and/or claims administration vendors to have the vendor either provide these required notices on behalf of the plan to comply with the Rule or provide all the required information related to the QPA for plans that self-administer claims.

Finally, the Rule states the participant cost sharing for air ambulance services must be based on the Recognized Amount/QPA; before the Rule, it appeared as if the QPA would not apply to air ambulance services. The Rule contains a slightly different methodology for determining the QPA for air ambulance services tailored to the provision of those services but follows the principles for determining and disclosing the QPA that applies to other Covered Services described above.

G. Timing of Initial Payment for a Covered Service

The Act requires plans to make an initial payment for Covered Services or issue a denial letter within 30 calendar days of receiving a claim. The Rule clarifies that this 30-day period begins on the date the plan or its designees receives all the information necessary to adjudicate the claim (referred to as a "Clean Claim"), which can delay the deadline by which the plan is required to adjudicate the claim.

Under the current DOL rules, a plan generally has 30 days to adjudicate a post-service claim and, if the plan does not have all the information necessary to adjudicate the claim, it must request that information before the 30-day period expires and then give the claimant 45 days to provide the requested information. Once the claimant provides the information, plans have 15 days to make the decision on the claim. If 45 days passes and no information has been provided, plans have 15 days to make the decision on the claim based on the information available.

In the preamble to the Rule, the Departments make clear that a plan would have 30 days from the date the claim was resubmitted with all requested information to make a determination, essentially giving plans an additional 15 days to adjudicate a claim for Covered Services. Plans may want to amend their plan documents to reflect this additional permitted time. However, the Rule and its preamble do not provide any guidance on how the timing works if the requested information is not provided. In the absence of any specific guidance to the contrary, plans still appear to have to adjudicate such a claim within 15 days under the DOL rules after the 45-day period expires.

II. EOB Disclosures on Protections Against Balance Billing

The Act requires plans to make publicly available, post on the plan's public website, and include in EOBs issued for Covered Services (except for air ambulance claims) a disclosure regarding the prohibition against balance billing. Although the Rule itself does not address this requirement, the preamble to the Rule says that a plan can use the same model notice issued by the Departments for use by providers and facilities to satisfy the Notice/Consent Requirements described above. The FAQs confirm this approach would be treated as good faith compliance.

Therefore, we recommend plans use this model notice, a copy of which is attached to this memorandum.

Unfortunately, the Rule does not address previously expressed concerns about whether the website requirement described above will require plans without websites to set one up to comply. It also does not address whether posting the notice on the plan's website is sufficient to make the notice "publicly available." Until clarifying guidance is issued, a reasonable approach would be for plans with a website to treat the posting as making the notice "publicly available." For plans without a website, in the absence of specific guidance requiring a website, a reasonable approach would be to circulate the notice to all participants prior to the effective date consistent with the disclosure method used by the plan for other DOL-required notices, such as an SMM or SPD, as a good faith effort to satisfy both the "publicly available" requirement and the requirement to post it on a website.

III. FAQs on the Transparency in Coverage Final Rule and the Consolidated Appropriations Act.

In addition to announcing the delayed enforcement dates discussed in the summary above, the FAQs provide limited guidance on what constitutes good faith compliance for certain provisions under the Act.

A. Good Faith Guidance for ID Card, Provider Directory, and Continuity of Care of the Act

The FAQs states that the Departments will conduct rulemaking addressing the following provisions of the Act, but do not expect regulations to be issued prior to their effective date under the Act: (1) ID card requirements; (2) continuity of care requirements; and (3) provider directory requirements. Until guidance is issued, the Departments expect plans to implement these provisions using a good faith, reasonable interpretation of the Act effective for Plan Years commencing on or after January 1, 2022. The Departments have advised that any future rulemaking on these issues will have a prospective applicability date so that plans will have time to implement procedures to comply with any new requirements.

1. *ID Card Requirements*

The FAQs provide an example of good faith compliance with the ID card requirements, indicating that a plan would be in good faith compliance if it includes on its physical or electronic ID cards the main major medical deductible and applicable out-of-pocket maximum and a website address or QR code that provides access to any other applicable deductibles and maximum out-of-pocket limits. For example, if a plan has a $1,000 deductible for out-of-network medical care and a separate deducible of $5,000 for dental services, it appears that only the $1,000 deducible is required to be included on the ID card, provided the ID card includes a website or QR code through which participants can obtain information about the $5,000 deductible for dental care.

The FAQs are not clear whether good faith compliance requires plans only to update electronic cards, or whether plans are required to issue new physical cards. Therefore, if a plan wants to provide only new electronic cards and not to issue new physical cards for 2022, or the

vendor handling ID card production will not issue new physical cards, the plan should discuss what approach they want to take. In making that decision, plans may want to consider participants who may not have access to electronic cards.

2. *Provider Directory Requirements*

In the FAQs, the Departments note that a plan will not be out of compliance with the provider directory requirements provided that, if an individual receives out-of-network items or services after being provided inaccurate information by the plan that stated the provider or facility was in-network via a provider directory or response protocol, the plan provides for in-network cost sharing (and counts it towards any in-network deductible or out-of-pocket maximum). Therefore, while plans should start working with their PPO network vendors to update provider directories and develop protocols to respond to participant inquiries to avoid such a result, the FAQs provide some relief for plans that are not able to comply with the short timelines associated with updating provider directories and responding to participant inquires, as discussed in our March 3rd memorandum. The other aspects of this requirement on which additional guidance will still be needed are not addressed in the FAQs and thus do not have to be addressed until future rulemaking is issued. These requirements include, but are not limited to, whether print directories need to be maintained and furnished, what contact information must be included for each provider in a directory and whether plans must have a link to the PPO network vendor's website on its website.

3. *Continuity of Care*

Under the Act and as noted in our March 3rd memorandum, plans must notify participants who are "continuing care patients" when an in-network provider leaves the network and also must permit that participant to elect to continue care with the provider as if the provider was still in-network for up to 90 days. The FAQs state that plans must make good faith efforts to comply with this requirement but provide no guidance on what that might entail. Therefore, plans will continue to have to work closely with their PPO network and/or claims administration vendor to develop a process to implement this requirement.

B. <u>Requirement on Prohibition of Gag Clauses and Delay in Attestation</u>

The FAQs state that the Departments do not intend to issue regulations addressing the CAA's prohibition on gag clauses on price and quality data that was effective December 27, 2020, as the Departments view the statutory language to be self-implementing. Plans are expected to comply with these requirements using a good faith, reasonable interpretation. In the absence of specific guidance, we believe one good faith interpretation of this requirement is the approach set forth in our March 9th memorandum: that any applicable new provider contracts or contract renewals effective on or after December 27, 2020 should be reviewed to comply with these rules. In such contracts, plans may want to insist on specific representations that any confidentiality and non-disclosure provisions do not apply to information subject to this gag clause prohibition. If the vendor refuses to accommodate this request, it is reasonable to treat a general contractual provision requiring compliance with applicable law to be sufficient to satisfy a "good faith" approach to this requirement, given the absence of guidance in the FAQ.

The Act also requires plans to make an annual attestation of its compliance with this requirement. The FAQs indicate that Departments will not issue guidance on annual attestations until 2022 at the earliest; thus it appears that the attestation requirement has effectively been delayed until further rulemaking is issued and there will be no obligation to comply with the statute in good faith until such rulemaking is issued.

C. Further Rulemaking for Machine Readable Files under Transparency in Coverage Final Rule and Price Comparison Tool under CAA

In light of the overlapping provisions of the Transparency Rule under the ACA and the CAA's price transparency rules, the FAQs state that the Departments intend to conduct further rulemaking on certain provisions to:

- consider whether the Transparency Rule's prescription drug machine-readable file requirement remains appropriate, given the potentially duplicative and overlapping pharmacy benefit and drug reporting requirements under the CAA;
- consider whether compliance with the Transparency Rule's price comparison tool requirements will also satisfy the Act's analogous price comparison tool requirements; and
- require the same pricing information that is available through the online price comparison tool or in paper form under the Transparency Rule to be provided over the telephone upon request, as is required by the Act's price comparison tool.

We will continue to keep you updated as further guidance is issued. In the meantime, please contact us with any questions.

cc: Co-counsel (if any)

Attachment

21017172v1

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact [*applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws*].

Visit [*website*] for more information about your rights under federal law.
[*If applicable, insert:* Visit [*website*] for more information about your rights under [state laws].]