

Consolidation Appropriations Act (CAA) No Surprises Act & Transparency in Coverage



Summary

Congress passed the Consolidated Appropriations Act 2021 (CAA) that is generally effective for plan years on and after January 1, 2022. Title I of the CAA includes:

- The No Surprises Act (NSA), prohibits surprise bills (or “balance billing”) when receiving emergency care or non-emergency care by an out-of-network provider at certain in-network facilities
- Updates to medical ID cards
- New consumer protections (Federal external reviews, advanced explanation of benefits (EOBs), etc.)
- New dispute resolution processes between payers and providers and members
- Updated provider directory requirements; and

Title II of the CAA includes certain provisions intended to create transparency:

- No gag clauses on price or quality for contract between health plans and providers
- Disclosures on direct and indirect compensation
- Updates to mental health parity requirements-nonquantitative treatment limitations
- Pharmacy benefit and drug cost reporting

A separate law, the Transparency In Coverage Final Rule (TiC), was also passed and requires disclosure of estimated costs to enrollees, negotiated in-network provider rates, historical out-of-network allowed amounts and billed charges, and drug pricing information.

Frequently Asked Questions

1. Who does the No Surprises Act apply to?

Answer – The NSA provisions apply to health care providers and all the Aspirus Health Plan lines of business including fully-insured individual, small group, and large group markets and self-insured (ASO) group plans administered by Aspirus Health Plan, including grandfathered plans.

2. How does the No Surprise Act Protect Patients?

Answer – Patients are protected from surprise medical bills by requiring health plans to cover most

- emergency services (provided at an emergency room, freestanding emergency department and urgent care centers licensed to provide emergency care) and
- non-emergency services including treatment, equipment, devices, telemedicine, imaging, lab at an in-network facility (e.g., hospitals, outpatient departments, ambulatory surgery centers and others)

that are provided by out-of-network providers.

The law also applies to air ambulance transportation (emergency and non-emergency). Emergency care includes screening and post-emergency stabilization services. The purpose is to make sure that patients are responsible for in-network levels of charges related to such services. Health care providers are also prohibited from billing patients for more than in-network cost sharing amount unless they obtain proper consent from the patient.

3. When are health plans impacted by the new laws?

Answer – Generally, certain aspects of the No Surprises Act are effective for plan/policy years beginning on and after January 1, 2022. However, the enforcement of some provisions has been delayed and/or postponed until rulemaking to implement certain requirements can be completed (e.g., Advanced EOBs, good faith estimates of expected charges, reporting on pharmacy benefits and drug costs).

Enforcement of the TiC rule for publicly available machine-readable files (in-network and out-of-network provider rate files) has been delayed to July 1, 2022. The price comparison tool requirement has also been postponed with a date to be announced pending further review of the price comparison tool requirements set forth under the No Surprises Act and the Transparency in Coverage Rule.

4. What is the impact to the Medical ID cards?

Answer – Under the NSA, until further guidance is issued, insurers are expected to implement this provision using a good faith effort by adding the following information to cards:

- Major medical deductibles
- Out-of-pocket maximum limits
- Telephone numbers and the website address for members to contact

5. What is the impact to the Provider Directories?

Answer – Under the NSA, until further rulemaking and guidance is issued, insurers are expected to implement this provision using a good faith effort to structure the directory and obtain updates from providers. This includes imposing in-network cost-sharing amounts for items and services furnished by a provider that was out-of-network, on the date such item or service was provided if a member relied on incorrect provider directory information that indicates the provider was in-network.

6. How will Aspirus Health Plan assist with the mental health parity provision of the No Surprises Act?

Answer –This CAA transparency provision was effective on February 2, 2021. Additional guidance was issued on April 2, 2021. Aspirus Health Plan will provide documentation for nonquantitative treatment limitations (NTQLs) to the appropriate regulators on request for fully insured plans.

Aspirus Health Plan will assist self-funded customers upon request. Please contact your Aspirus Health Plan account management representative for more information.

7. What is Individual Dispute Resolution (IDR) under the No Surprises Act?

Answer – Aspirus Health Plan will align with requirements to resolve billing disputes with out-of-network providers when members do not affirmatively opt to receive an item or service from an out-of-network provider. IDR does not apply to claims that are denied for medical necessity reasons (standard appeals process remains). IDR may be requested by a provider or health issuer/health plan four (4) days after the end of a 30-day open negotiation period between the provider and the health plan that does not result in a resolution. *(Note: Interim final rules about IDR were issued on October 7, 2021 with the 60-day public comment period ending on December 6, 2021. Final rules are anticipated in late 2021 or in 2022.)*

8. What is an Advanced EOB?

Answer –An estimate of costs that is provided to member before scheduled care or services or upon request of a member or a health care providers seeking a good faith estimate of care. Members may elect to receive this information electronically or by mail. This is not required for excepted benefits (e.g., vision, certain dental). *Note: This requirement has been delayed pending additional guidance.*

9. What is the machine-readable file requirement under the Transparency in Coverage rule?

Answer –

- The Transparency in Coverage Rule requires public disclosure of negotiated in-network provider rates and out-of-network allowed amount and bill charges for items and services covered by a health plan/policy.
- Aspirus Health Plan intends to meet the July 1, 2022 enforcement deadline for the in-network and out-of-network rate files.
- The third machine-readable file for drug pricing information has been deferred until further rulemaking is provided. This requirement is under review to determine duplicity with the prescription drug reporting requirements under Section 204 of the No Surprises Act.

10. What is the cost comparison tool requirement under the Transparency in Coverage rule?

Answer –

- The Transparency in Coverage Rule requires the provision of a tool that furnishes personalized estimated cost-sharing information and other information to a member upon request and prior to receipt of care
- Aspirus Health Plan intend to meet the requirements (500 items, services, and drug costs) and will be provided via phone or a web-based tool.
- Aspirus Health Plan intends to meet the 1/1/2023 deadline. *Note: enforcement has been delayed pending additional rulemaking.*

11. How can members get more information on the No Surprises Act and Transparency in Coverage provisions?

Answer –

- For information on NSA, members can go to <https://www.cms.gov/nosurprises>
- For information on TiC, members can go to <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f>