

# No Surprises Act And Transparency In Coverage Final Rule:

## 4 Compliance Challenges TPAs Face



On December 21, 2020, Congress passed the Consolidated Appropriations Act (CAA), establishing protective measures for consumers regarding surprise billing and transparency in health care. As part of the CAA, a foundational set of laws and regulations was established, requiring insurance companies and employer-based health plans to adhere to standards of compliance. Among these regulations, the most notable requirements fall under the branches of the Transparency in Coverage Rule (TiC) and the No Surprises Act (NSA).

As of the publishing of this paper, future rulemaking, and announcement of reporting deadlines regarding this law are still forthcoming, allowing for plans and insurers to modify contractual agreements, develop new procedures, and compile all necessary data. However, for now, given the guidance that has so far been laid out with the release of the Final Rule on August 19, 2022, here are **four** specific challenge areas that Third Party Administrators are facing.

### 1. Qualifying Payment Amount: No Surprise Billing

The Qualifying Payment Amount (QPA) is the average or median in-network rate for services rendered in a similar geographic region that insurers are required to provide as a part of compliance to determine the patient's cost-sharing responsibility.<sup>1</sup>

In the summary of the August 19, 2022, Final Rule pertaining to QPAs, plans and their issuers are required to “Disclose the QPA for each item or service to providers, facilities, and providers of air ambulance services with each initial payment or notice of denial of payment when the QPA serves as the amount upon which cost sharing is based.”

QPA compliance also relies heavily on the demonstration of *good faith efforts* for plans and issuers to come to an agreement on the contracted rates. Outside of the law-making special allowances for events in which the insurer was not present in a given market or did not cover a specific service in the year 2019, insurers are otherwise expected to properly calculate median contracted rates accordingly.

**Having the systems and tools in place to accurately provide QPAs is essential for future compliance requirements**, specifically with the requirements around Advanced Explanation of Benefits (EOBs).

## 2. MRF Compliance

On July 1st, 2022, the first phase of the Transparency in Coverage Rule came into effect, requiring health insurance issuers to have reached full machine-readable file (MRF) compliance, publishing MRFs on their negotiated rates, out-of-network allowed amounts. Prescription (Rx) coverage rates and allowed amounts have been delayed to a later date TBA. In addition, the TiC rule mandates that health insurance issuers meet update requirements on a recurring monthly basis going forward.

The consequences of non-compliance can be catastrophic: **the cost of non-compliance is \$100 per covered plan participant per day.** Plans with over 500 enrolled employees could potentially expect fines in excess of \$15,000,000 per year for non-compliance.

There are several ongoing compliance challenges for plans and groups related to MRFs, not just for those responsible for creating the files and file infrastructure, but also for the public consumers of the files.

Data duplication and redundancy among the MRFs will be challenging for health plans to manage and mitigate. Additionally, the file sizes to meet CMS requirements will very likely not be downloadable for most users due to the extremely large file sizes. Hosting the files poses a costly challenge for health plans.<sup>2</sup>

While the Final Rule determined group health plans may enter into a written agreement with a service provider to post the machine-readable files on their behalf, **affordably maintaining MRF compliance will be an ongoing challenge for many.**

## 3. Price Comparison and Cost Estimator Self-Service Tool

As stated in the recent release of the Final Rule, self-insured plans are required to offer a web-based price transparency tool for 500 services beginning **January 1, 2023.**<sup>3</sup> On January 1, 2024, all services must be included. This tool must communicate the expected costs of services provided in a plan member's service area, enable participants to compare cost amounts for items and services of in-network providers for specific regions, and make price comparison information available via telephone.

The purpose of the Price Comparison and Cost Estimator Self-Service Tool is to provide participants with a fully transparent experience when shopping for healthcare services and potentially lower overall healthcare expenditures. The major benefits for plan members include lower costs and fewer surprises in billing – specifically, from out-of-network providers.

Compliance in this category places an enormous administrative burden on health plans, and, in the case of self-funded plans, **the burden for meeting price transparency requirements falls on third-party administrators.** With 2023 quickly approaching, time is of the essence to build, test, and implement this tool.



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## 4. Administration Costs & Capabilities

In addition to the multi-level burdens that TPAs must face to ensure compliance for their clients, they may also find that the challenge of navigating these transparency laws and bylaws is incredibly complicated and expensive to administer.

Making matters even worse, the No Surprises Act adds confusion by requiring that coverage be provided with zero limitations on any event that can be classified as an emergency medical condition, but this process of classification is solely based on diagnosis codes, such as the ICD-10 codes. In fact, it is customary for many claims administrative systems to automatically deny an emergency claim if that same emergency claim is listed on a predetermined schedule of final diagnosis codes, with no regard given to any actual symptoms presented during a member's time of care.

Ultimately, the majority of self-funded employers, brokers, and plan sponsors **rely on their TPA to guide them and provide the means and services for compliance.**<sup>4</sup> The additional technology, administrative tools, and time required will likely become the new normal for TPAs moving forward.

## Clarity on Transparency with Transparency+ by Integrated Payor Solutions



Understanding the complexities surrounding TiC and NSA compliance, we built **Transparency+** to be the most affordable, adaptable solution to meet all current and future regulations. **Built on the dynamic Salesforce platform**, Transparency+ is the industry's only **cloud-based, stand-alone, bolt-on solution** for the No Surprises Act.

Transparency+ is easy to integrate with any existing tech stack and fulfills all key components required by the No Surprises Act for **Machine-Readable Files, Price Comparison Tools, Advanced EOBs, and Qualifying Payment Amounts**, including:

- Provider and facility network status
- In-network contract rates
- Out-of-Network estimates
- Expected participant cost share
- Deductible annual accrual estimate
- Participant out-of-pocket maximum
- Procedure medical requirements
- Required disclaimers

We understand the importance of meeting the compliance enforcement deadlines, which is why Transparency+ has a **60-day average** implementation, so requirements can be met quickly.

### Learn more about Transparency+ by scheduling a demo:



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#### References

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- 3 <https://www.federalregister.gov/documents/2022/08/26/2022-18202/requirements-related-to-surprise-billing>
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