FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 53

April 19, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act (ACA). These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resourcecenter/faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

Transparency in Coverage Machine-Readable Files

The Transparency in Coverage Final Rules (the TiC Final Rules) require non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose, on a public website, information regarding in-network rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files.[1] The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022. The Departments previously announced that they will defer enforcement of the requirements related to machine-readable files disclosing in-network and out-of-network data until July 1, 2022.[2] The Departments also previously announced that they will defer enforcement of the requirement that plans and issuers publish a machine-readable file related to prescription drugs while they consider, through notice-and-comment rulemaking, whether this requirement remains appropriate.[3]

The TiC Final Rules require plans and issuers to publish all applicable rates, which may include one or more of the following: negotiated rates, underlying fee schedule rates, or derived amounts for all covered items and services in the In-network Rate File. The Departments specify in the preamble to the TiC Final Rules that the In-network Rate File requirement applies to plans and issuers regardless of the type of payment model or models under which they provide coverage.[4]

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[1] 26 CFR 54.9815-2715A3; 29 CFR 2590.715-2715A3; and 45 CFR 147.212; 85 FR 72158 (Nov. 12, 2020).
[2] *See* FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49, Q 2, available at: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf.
[3] *See id.* at Q 1.
[4] 85 FR at 72226.

If the plan or issuer does not use negotiated rates for reimbursement of items and services, the plan or issuer must report derived amounts, to the extent those amounts already are calculated in the normal course of business. The TiC Final Rules do not require plans or issuers to develop a new methodology for providing derived amounts. If the plan or issuer uses underlying fee schedule rates for calculating cost sharing, the plan or issuer should include the underlying fee schedule rates in addition to the negotiated rates or derived amounts.

Notably, the TiC Final Rules require that these rates be reflected in the In-network Rate File as dollar amounts. While there are many alternative reimbursement arrangements that do not have a dollar amount associated with particular items and services before the item or service is provided or rendered, a dollar amount can still be determined in some instances under these models. Accordingly, in the preamble to the TiC Final Rules, the Departments provide a list of alternative reimbursement arrangements and summarize general reporting expectations for these models, while acknowledging that this list is not exhaustive, as there may be other alternative reimbursement or contracting arrangements in use.[5] Specifically, the Departments summarize the general reporting expectations for several alternative reimbursement arrangements, including bundled payment arrangements and capitation arrangements (including sole capitation arrangements and partial capitation arrangements), reference-based pricing without a defined network, reference-based pricing with a defined network, and value-based purchasing. For example, the preamble clarifies that for payment arrangements under which adjustments are made after care is provided, the plan or issuer should disclose the base negotiated rate before adjustments are applied.[6]

After the TiC Final Rules were issued, stakeholders have utilized GitHub and other forums to raise to the Departments' attention alternative reimbursement arrangements for which reporting a current and accurate dollar amount for items and services in the In-network Rate File before the item or service is provided or rendered may not be possible. Specifically, stakeholders have asked the Departments how to report dollar amounts for negotiated rates that result from certain "percentage-of-billed charges" contract arrangements, under which a dollar amount can be determined only retrospectively because the agreement between the plan or issuer and the in-network provider states that the plan or issuer will pay a fixed percentage of the billed charges. It is the Departments' understanding that these types of arrangements are not uncommon for certain types of items or services (such as low-volume procedures or high-cost, outlier inpatient care) and that plans and issuers may enter into these arrangements, in part, because the arrangements include limitations on a provider's ability to charge amounts for furnished items and services that significantly vary from an established rate schedule (such as a hospital's chargemaster)—though the rates reflected in such a schedule may not necessarily be the amounts charged. Thus, plans and issuers may be able to estimate the potential range of rates in advance, but they cannot determine accurate dollar amounts until a claim is made.

[5] *Id.* at 72158, 72226.
[6] *Id.* at 72228.

To address these situations, the Departments are providing an enforcement safe harbor for satisfying the reporting requirements for plans and issuers that use alternative reimbursement arrangements that do not permit the plans and issuers to derive with accuracy specific dollar amounts contracted for covered items and services in advance of the provision of that item or service, or that otherwise cannot disclose specific dollar amounts according to the schema as provided in the Departments' technical implementation guidance through GitHub. This safe harbor is further described in Q1 and Q2 of these FAQs Part 53.

The Departments will monitor the implementation of the machine-readable files requirements and may revisit this safe harbor in the future, including when access to underlying fee schedules becomes more widely available in connection with the development of pathways for providers to transmit expected charges to plans and issuers in support of the development of advanced explanations of benefits as required under Internal Revenue Code section 9816(f), the Employee Retirement Income Security Act section 716(f), and the Public Health Service Act section 2799A-1(f), as added by Section 111 of title I (the No Surprises Act) of division BB of the Consolidated Appropriations Act, 2021.[7] HHS encourages states that are primary enforcers of this requirement with regard to issuers to take a similar enforcement approach and will not regard a state as failing to substantially enforce this requirement if it takes such an approach.

This safe harbor will not apply to a particular alternative reimbursement arrangement if the Departments determine that the particular arrangement can sufficiently disclose a dollar amount. The Departments encourage the continued utilization of GitHub to submit suggestions on ways the schema should support alternative reimbursement arrangements.

Q1: In the In-network Rate File, how can plans and issuers report applicable rates for specific items or services provided under "percentage-of-billed-charges" contracts if an exact dollar amount cannot be determined for those items or services prospectively?

For contractual arrangements under which a plan or issuer agrees to pay an in-network provider a percentage of billed charges and is not able to assign a dollar amount to an item or service prior to a bill being generated, plans and issuers may report a percentage number, in lieu of a dollar amount. For example, if a negotiated arrangement for a particular item or service provides for reimbursement for 70 percent of billed charges, and the plan or issuer is unable to ascertain the dollar amount that will be billed for the item or service in advance, the Departments will permit the plan or issuer to report the in-network rate using the applicable percentage of 70.

Documentation specific to the format requirements for percentage-of-billed-charges arrangements can be found here: https://github.com/CMSgov/price-transparency-guide/tree/master/schemas/in-network-rates#negotiated-price-object.

[7] Pub. L. No. 116-260 (2020).

Q2: In the In-network Rate File, how can plans and issuers report applicable in-network rates for items and services provided under alternative reimbursement arrangements that are not supported by the schema or require additional context to be understood?

In situations in which alternative reimbursement arrangements are not supported by the schema, or in instances where the contractual arrangement requires the submission of additional information to describe the nature of the negotiated rate, plans and issuers may disclose in an open text field a description of the formula, variables, methodology, or other information necessary to understand the arrangement. The open text field may be utilized for reporting only if the schema—as provided in the Departments' technical implementation guidance through GitHub—does not otherwise support the arrangement.

Documentation specific to use of the open text field can be found here: https://github.com/CMSgov/price-transparency-guide/tree/master/schemas/in-network-rates#negotiated-price-object.

**Part of FAQs Set 53 has been superseded by FAQs Set 61 located at https://www.cms.gov/files/document/faqs-about-affordable-care-act-implementation-part-61.pdf.*