CBA Blue

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Transparency In Coverage Rule and Consolidated Appropriations Act Overview and FAQ

For Clients & Brokers

March 21, 2022

Contents

Overview & Resources

The passage of the Consolidated Appropriations Act, 2021 (CAA) added many new compliance requirements for group health plans. In addition, the Departments of Health and Human Services, Labor and Treasury (the Departments) have issued regulations implementing the Transparency in Coverage Requirements (TCR) under the Patient Protection and Affordable Care Act (ACA) that also impact group health plans. The requirements of the No Surprises Act (NSA) under the CAA also began to take effect in January 2022.

Much of the new rules aims to increase the availability and transparency of health care price information to consumers to enhance market competition and lower health care prices. These changes follow the Hospital Price Transparency final rule, which required hospitals to make public a variety of pricing information and went into effect on January 1, 2021.

The two (2) core requirements are to:

1**. Disclose to the public [i] in-network provider negotiated rates**, [ii] historical out-of-network allowed amounts, and [iii] drug pricing information through three (3) separate machine-readable files (MRFs) posted on an internet website.

2. **Disclose cost-sharing information upon request to a participant**, beneficiary, or enrollee -including an estimate of the individual's cost-sharing liability for covered items or services via an online tool, and in paper or by telephone if requested.
The Rule adopts a three-year, phased-in approach for compliance with the Rule, which requires Plans and Issuers to provide:

- Public access to the in-network and out-of-network machine-readable files for plan (or policy) years that begin **on or after July 1, 2022**;
- Cost-sharing information to participants, beneficiaries, or enrollees for 500 specified items and services for plan (or policy) **years that begin on or after January 1, 2023**; and
- Cost-sharing information to participants, beneficiaries, or enrollees for all covered items and services for plan (or policy) **years that begin on or after January 1, 2024**

The following sections are meant to update our brokers, consultants and plan sponsors as to where CBA Blue currently stands in relation to compliance with the pertinent provisions outlined within the various pieces of recent legislation.

Resources

CMS Transparency in Coverage Fact Sheet

Tri-Agency FAQ

Machine Readable Files

Requirements for July 1, 2022

The final rule requires health plans to provide publicly two separate machine-readable files that include pricing information:

1. the IN negotiated rates with their providers; and
2. the historical payments to OON providers and their billed charges.

These files must be made accessible via a public website at no additional charge, cannot require a log-in or account, and be updated monthly. The files must, in part, also include plan option/coverage identifier information; billing codes to identify items and services for claims processing; and all applicable rates. Plans and issuers will display these data files in a standardized format and will provide monthly updates. The historical prices are for the 90-day time-period that begins 180 days prior to the file publication date.

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

Yes. We intend to be compliant with these requirements of the rule. CBA Blue will assist plan sponsors in making the two machine-readable files available (in-network rates for covered services or item covered by the plan, historical billed charges from out-of-network providers and the allowable amount of such charges considered by the plan). Links to the files will be posted on CBA Blue's website and we are actively engaged with our parent organization (BCBSVT) in outlining the web page designs needed and coordinating how the in-network files will be made available prior to the July deadline.
A pharmacy machine readable file is no longer required at this time.

Disclosure of Out of Pocket (OOP) Costs

Effective January 2023 and January 2024
The Transparency in Coverage Rule (TCR) requires insurers and plans to provide consumers with personalized cost-sharing information for both medical and prescription drugs, including estimates of their out OOP costs by service via an on-line tool, or paper, if requested. The Tri-Agencies recently issued an FAQ that indicates they expect to fold the CAA Cost Tool requirement to support cost estimation via the phone upon request, into the TCR, as well.

The regulations on price comparison tools outlined in the CAA have been determined to be duplicative of those that are outlined under the Transparency in Coverage final rule. Therefore, the consumer tool requirements will begin in alignment with existing TCR language for price comparison tools for the HHS-determined 500 items/services, on and after January 1, 2023.

What the is due date for consumers to have access to this information?

- January 1, 2023: an initial list of 500 shoppable services as determined by the Departments for plan years that begin on or after January 1, 2023.
- January 1, 2024: the remainder of all items and services will be required for plans years that begin on or after January 1, 2024.

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

Yes. We are making good faith efforts in meeting all compliance requirements. We intend to be compliant with the requirements of the rule. We expect to be prepared to support the self-service tool requirements for covered services for self-funded accounts for both TCR and CAA as per the rules and future rulemaking.

How will the cost comparison tool be made available to members?

The Cost Comparison Tool will be made available through a SSO (Single Sign On) connection within our secure member portal to ChangeHealth Care's TrueView product.* With this connection, an API (Application Programming Interface) connection will produce the real-time price comparison and cost sharing information. Our member services staff will also have access to produce cost estimates on behalf of our members via the phone and written procedures.

Surprise Billing

Title I of Division BB of the CAA (the No Surprises Act) within the CAA establishes new protections from surprise billing and excessive cost-sharing for consumers receiving certain medical health care items and services.

The No Surprises Act:

- Protects members from balance billing when receiving certain services under certain circumstances.
- Provides for patients to be responsible for only in-network cost-sharing amounts, and requires claims be applied to in-network cost-sharing, including deductibles and out-of-pocket maximums, in emergency and certain non-emergency situations.
- Also applies to air ambulance services (ground ambulance services excluded).

In addition to the prohibitions on surprise billing, the No Surprises Act requires providers and insurers to negotiate provider payments should either party not be satisfied with the proposed rate of payment.

If the insurer and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) process, also referred to as arbitration, will be deployed to determine the reimbursement amount.

This provision took effect for plans on or after January 1, 2022.

Is CBA Blue currently compliant with this TCR requirement?

Yes. We are compliant and have updated our claims processing system accordingly.

- For those SPDs that CBA Blue produces on behalf of clients, we have incorporated NSA-compliant language within full SPD restatements or SMM Amendments. For SPDs we do not produce, we encourage clients to seek outside legal assistance to ensure appropriate NSA-compliant language is incorporated.
- We have completed the implementation of our CBA Blue QPA (Qualifying Payment Amount), which we have begun to apply to surprise billing services to determine the member cost sharing amount and the initial payment to a provider.

- The Surprise Billing Notice explains to members their rights regarding surprise balance billing. These notices will be mailed along with member EOBs for NSA-protected claims. The notice will also be posted on CBA Blue's public website.

- On January 1, 2022, the Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities became available. The document includes information on how the parties to a payment dispute may initiate the process and how to request an extension of certain time periods for extenuating circumstances. It also addresses the requirements that certified IDR entities must follow in making a payment determination and the process for revocation of IDR certification.

  Please note that any fees associated with the IDR process and charged by the certified IDR entities will be directly charged back to clients. We will continue to share additional information on how this process will work and how the fees will be assessed once we have more information and encounter such circumstances. CBA Blue will facilitate the IDR process and the external appeal process for surprise billing protected claims.

Advance EOB (AEOB)

The CAA requires providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a good faith estimate to the payer (if the patient is enrolled in a plan or insurance coverage and intends to use the coverage) three days in advance of a scheduled service.

The AEOB will be triggered by the notification from the provider and/or facility or upon request of the patient of authorized representative. Individual and group health plans will be required to provide an advance EOB for scheduled services at least three days in advance of a service. If the service is scheduled within three days of the request, the AEOB must be provided to the member within one business day and if the service is scheduled within 10 days of the request, the AEOB must be provided within three business days.

Advanced EOBs are to be delivered to members either electronically or via postal mail, as requested by the member and include service details received from the provider(s); the providers network status; negotiated rate information and actual plan liability for the service; and amu relevant disclaimer information on medical management requirements that apply to service.

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

Given the concerns from stakeholders regarding the ability to build good faith estimates as noted above, the Departments now acknowledge that AEOB compliance was not possible by 1/1/22.

The Departments intend to develop a new notice and rulemaking process to implement this provision; until that time, Departments will defer enforcement of AEOBs. Consistent with other carriers, CBA Blue is awaiting further direction and clarification from the Departments on specifics of this provision.

Continuity of Care

The new protections for defined patients during a course of medical care are effective for the first plan year beginning on or after January 1, 2022. The Act determines timely notification to a member if a health provider is removed from a plan's network following termination of the network contract between the plan and provider.

When this occurs, the plan or insurer must notify members who are receiving care from the provider that:

- The provider is no longer part of the plan's network.
- The participant has the right to continue receiving transitional care from the provider.
- The plan must cover the transitional care provided by that former plan network provider at the in-network coverage level during the transitional care period.

Plans are required to give the participant the opportunity to request a transitional care period. The period must extend for the remaining time that the participant is a patient at a continuing care facility or for up to 90 days after the plan participant(s) receives notification from the plan that the provider is no longer in their network.

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

We are ready to timely furnish notice to those enrollees receiving ongoing care from a provider/facility leaving the plan network. Such notices will be furnished to those individuals (known as continuing care patients) receiving treatment for serious or complex health conditions, institutional or inpatient care, nonelective surgery, pregnancy, and care for terminal illness.

Mental Health Parity & Addiction Equity Act

Health plans may now be audited to ensure mental health benefits are comparative to medical/surgical benefits. In response to this, clients must be prepared for federal audits based on the DOL self-service tool. **This provisions took effect on 02/10/2021.**

Is CBA Blue be prepared to be compliant with this requirement of the TCR?

Yes. Though we have built an in-house analysis (which has proven to be adequate for several DOL audit performed over the last few months), we are unable to adequately test at the plan level and recommend a true NQTL analysis which is available at a cost through our trusted partners (MZQ** via our relationship with The PHIA Group***). A quote for the analysis can be requested through your Account Manager.

Provider Directories

Provider Directories provision requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days.

The requirements below are from the CAA legislative text, and it is assumed further clarification, detail and date confirmation for compliance will be detailed in the regulatory text sometime this year. We are working to mitigate, and plan based on limited current information, and may need to adjust our roadmap based on further specifics. We will continue to update our clients as we receive more details.

Until further rulemaking is issued, plans and issuers are expected to implement provider directory provisions using a "good faith compliance" approach. Pending any future implementing rulemaking, the Departments clarify that "good faith compliance" requires plans and issuers to impose in-network cost-sharing where a participant receives items or services from a nonparticipating provider and the participant was provided inaccurate information by the plan or issuer through a provider directory or other response protocol.

- Requires plans to establish a response protocol to respond to member network questions within one business day and retain communications for at least two years.
- If a member provides documentation that they received incorrect information, the patient will only be responsible for in-network cost-sharing.
- Requires providers to update directory information and provide refunds to enrollees (in certain circumstances).
- Requires update of directory information within 2 business days of plan or issuer receiving from a provider or facility information.
- The data elements that must be updated in directory information are defined by the CAA:

**For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.*

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

Yes. CBA Blue utilizes the BlueCross BlueShield National Doctor and Hospital Finder which is compliant with the rule's provider directory requirements and verification process. The information in this directory comes from the various BlueCross Blue Shield Plan networks from around the country.

Several communications have been sent to the networks, to ensure that they are aware of and continue to comply with directory requirements.

ID Cards

Effective 1/1/2022, plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the plan or coverage:

- any deductible applicable to the plan
- any maximum out of pocket limits applicable to the plan
- telephone number
- internet website address where an individual can seek consumer/member assistance

Is CBA Blue currently compliant with this TCR requirement?

Yes. CBA Blue began implementing this requirement mid-2021 and is coordinating the issuance of additional physical 2022 ID cards with the added required information.

We will be wrapping up the client reprints between now and year end. As we move forward through 2022, subsequent renewal months will be receiving ID card reprints in compliance with NSA provisions.

Prescription Drug Reporting

To better understand prescription drug pricing trends and their impact on premiums and individuals' out-of-pocket costs health plans must submit prescription drug information to the Departments, including but not limited to

- top drugs dispensed
- most costly drugs
- rebate information

Will CBA Blue be prepared to be compliant with this requirement of the TCR?

Yes. It is our intention to comply with all requirements of the CAA. CBA Blue is actively assessing the CAA and components related to the Prescription Drug reporting provision for our preferred PBM arrangements – as much of the information is PBM dependent.

Once more information and guidance has become available, we will work with our clients to ensure compliance with regulatory deadlines.

Please Note: Plan Sponsors who "carve-out" the prescription benefit component from their health plan offering should speak with their consultant or PBM directly.

BCBS Association and affiliation note:
The below listed vendors are not associated with BCBS association

*ChangeHealthCare (referenced on page 4)
**MZQ (referenced on page 6)
***The PHIA Group (referenced on page 6)