

## Transparency Requirements

Your health plan strongly supports greater transparency and is committed to providing members with the health care quality and price information they want and need to make the best decisions for themselves and their families.

Our 20 years of experience with consumer tools tell us that most people want clear information about their own out-of-pocket costs, the quality of care provided by their doctors, and whether their doctors, hospitals, and other clinicians are in their network.

We want shopping for elective medical services to become part of the click-and-compare world. Today, the independent licensees of the Blue Cross Blue Shield Association (BCBSA) provide cost transparency tools to consumers in every state, many of which allow consumers to obtain information on the cost and quality of certain procedures, while safeguarding consumer information. These tools are tailored to the consumers' own coverage and benefits, including information on copays and progress toward meeting deductibles.

To address the Consolidated Appropriations Act (CAA)/No Surprises Act (NSA) and the Transparency in Coverage Rule (TCR), your health plan has established procedures for implementation of regulatory guidance, in which we have dedicated workstreams to execute internal procedures, which includes required technology, for each requirement within these requirements. Our organization is on track to be compliant by the applicable effective dates of Jan. 1, 2022, Jan. 1, 2023, and Jan. 1, 2024, and continues to keep a pulse on additional anticipated rulemaking.

[Here are some answers to common questions:](#)

### **Machine Readable Files**

#### **What data will be provided and when?**

The requirement to post machine-readable files is effective for plan years starting on or after January 1, 2022. On August 20, 2021, the Departments of Labor, Treasury and Health and Human Services (Departments) announced that they would defer enforcement of this requirement until July 1, 2022 for in-network and out-of-network files. An updated enforcement date for the Prescription Drug file has not been announced.

Your health plan will make the in-network and out-of-network allowed amounts available on July 1, 2022 as required by the final and updated enforcement timeframe issued by the Departments. Your health plan continues to monitor agency guidance and FAQs published by the Departments.

#### **How will your health plan support clients?**

Your health plan will be publishing the in-network and out-of-network files to a public website. The files will be in a JSON format, following the CMS approved schema, and updated monthly per the Transparency in Coverage Rule. This is the solution for self-funded (ASO) and fully insured clients.

The MRF files will be available to the public without restriction. A user account, password or any other credential will not be required.

**Where will the files be posted?**

The website is [mrfddata.hmhs.com](http://mrfddata.hmhs.com), that will be activated on July 1, 2022.

**How will clients find their information?**

Clients will be able to navigate to their information by searching on their employer identification number (EIN) by using the Ctrl+F feature.

Your health plan would like to remind our clients that compliant MRFs will be large in size and are not consumer friendly since the CMS approved schema is targeted for machine ingestion rather than consumer download. If members are looking for the best and most affordable care, we encourage the utilization of our cost estimator tool.

**Is there a cost associated for MRF support?**

At this time, your health plan is not passing any costs to clients for activities being performed to comply with requirements

**What role has BCBSA played in ensuring readiness?**

BCBSA developed multiple resources to ensure readiness amongst its licensees. These resources include a procedural manual and file transfer access instructions. BCBSA has provided a data file layout for the in-network file exchange through their Data Hub for inter-plan products and coverages. Additionally, BCBSA has held subject matter expert meetings for machine-readable files to assist with the development of the in-network file solution. Lastly, BCBSA is requiring all licensees to complete milestone surveys so they can keep a pulse on the progress of their implementation.

**What is the Price Comparison Tool?**

TCR rules require plans to make price comparison information available to members through an internet-based self-service tool and in paper form, upon request. This information must be available for plan years beginning on or after Jan. 1, 2023, with respect to the 500 items and services and with respect to all covered items and services, for plan or policy years beginning on or after Jan. 1, 2024.

The CAA requires plans to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that, to the extent practicable, allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider. This requirement is applicable with respect to plan years — or, in the individual market, policy years — beginning on or after Jan. 1, 2022.

Today our cost estimation tools are powered by BCBSA data and developed in accordance with BCBSA rules. There is a team of cross-disciplinary representatives from your health plan and the BCBSA that are determining how changes in the regulatory environment may affect how we display cost.

Your health plan currently provides an internet-based self-service price comparison/cost estimation tool that allows members and providers to obtain information on the cost of certain procedures, which meets the requirements set forth within the CAA, as the law is currently written. For the TCR, your health plan is enhancing our internet-based self-service tool to include the identified 500 shoppable services and the required data elements. Additionally, effective Jan. 1, 2024, your health plan is enhancing an internet-based self-service tool to include all covered items and services, including prescription drugs and durable medical equipment.

### **ID Card (cost share transparency)**

All health plan members will receive new member ID cards in 2022. The new ID cards will be issued upon client renewal, or upon the anniversary of the client's Plan Year, whichever comes first. New card formats that display the individual and family program deductible and Out-of-pocket Maximum/Limit have been developed for all health plan products. Based on experience and evolving regulatory guidance, additional changes to some card formats to improve readability and better align with regulations will be implemented in 2023. Mass reissues of cards are not planned for 2023. Going forward, if a group makes benefit changes that impact the benefit information on their card (such as increase in deductible), new cards will be issued for all members of the group.

### **Advanced EOBs**

Health plans are required to provide an advanced explanation of benefits ("EOB") for scheduled services. We anticipate the Tri-Agencies to release data transfer standards, and will finalize our solution once additional notice-and-comment rulemaking is published. The Advanced EOB requirement effective date has been delayed by the regulatory agencies and will be implemented at a future date still to be determined.

### **Contractual Gag Clauses**

The CAA prohibits plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations. In addition, plans must annually submit to the agencies an attestation of compliance with these requirements. These provisions are effective Dec. 27, 2020, which is the date of enactment of the CAA.

Your health plan provider contracts do not include gag clauses. Furthermore, your health plan will comply with applicable disclosure provisions of the CAA subject to the execution of an appropriate confidentiality agreement.

## **Accurate Network Directories**

The CAA requires plans to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status. If a participant, beneficiary, or enrollee is furnished an item or service by a nonparticipating provider or nonparticipating facility, and the individual was provided inaccurate information by the plan or issuer under the required provider directory or response protocol that stated that the provider or facility was a participating provider or participating facility, the plan or issuer cannot impose a cost-sharing amount that is greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider or participating facility and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum. These provisions are applicable with respect to plan years — or, in the individual market, policy years — beginning on or after Jan. 1, 2022.

Your health plan is implementing new software and procedures that require contracted providers to verify their critical demographic information in your health plan's provider directory every 90 days. In addition, internal processes are being updated to ensure all provider information updates received by your health plan are reflected in the provider directory within 48 hours of receipt.

## **What is the No Surprise Billing disclosure?**

No Surprise Billing disclosure language that complies with the NSA has been posted on your health plan's member portal. [There is a No Surprises Act link at the bottom of your health plan's home pages (that links to a page which contains general information about the No Surprises Act.) Similar disclosures will appear on EOBs for services rendered by out-of-network providers. In addition, new claim line-specific messages will appear on EOBs for claim lines that are identified as subject to No Surprise Bill regulations.

We will provide information (including updated member benefit booklets) to help clients update their SPDs to reflect the requirements of the NSA.

## **What benefit changes are required due to the No Surprises Act?**

Plans subject to the NSA must provide benefits at the network level of cost sharing whenever certain covered services are rendered by out-of-network providers. As a result, many groups will need to make benefit changes when they renew in 2022 to comply with the NSA.

1. Cover emergency claims at the network level of benefits (subject to network deductible, OOP, TMOOP, and copay/coinsurance) when provided by an OON provider. Services must be covered at the highest tier for tiered products. This includes both Facility and Professional claims but does not include Ambulance claims.
2. Cover (emergency and non-emergency) Air Ambulance claims (if Air Ambulance services are a covered benefit) at the network level of benefits (subject to network deductible, OOP, TMOOP, and copay/coinsurance) when provided by an OON provider. Services must be covered at the highest tier for tiered products.

Air Ambulance services are standardly covered by your benefit plans, but the Act does not require groups to cover Air Ambulance services. Your plan will continue to review certain Air Ambulance claims for medical necessity and will deny claims that do not meet medical necessity criteria as outlined in your health plan's medical policy.

### **Continuity of Care**

The CAA established continuity of care protections that apply in the case of an individual with benefits under a group health plan. These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status. These provisions are applicable with respect to plan years beginning on or after Jan. 1, 2022. Until rulemaking to fully implement these provisions is adopted and applicable, plans are expected to implement the requirements using a good faith, reasonable interpretation of the statute.

Continuity of Care (COC) is an existing process that allows members to receive treatment from OON providers at the network level benefits under specific circumstances. The process itself is not changing substantially as a result of the NSA.

What is changing is that the population of members eligible for COC has been expanded by the NSA. When there is a change in your health plan's provider network (i.e., the provider/facility is no longer contracted with your health plan, the provider/facility leaves your health plan's network, or if the provider/facility is moved from a broad to narrow network), members undergoing continuous care may continue to receive services from the now out-of-network provider for up to 90 days under the terms and conditions that were applicable prior to the change to allow for a transition of care to an in-network provider.

If the patient chooses to continue with their current provider, the provider must accept the previous in-network payment and cost-sharing rates for those 90 days, or until the treatment is concluded, whichever is sooner.

The legislation defines continuing care patients as those who:

- Are undergoing a course of treatment for a serious and complex condition.
- Have an acute illness serious enough to require specialized medical treatment to avoid death or permanent harm.
- Have a chronic illness that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized care.
- Are receiving institutional or inpatient care.
- Are scheduled to undergo nonelective surgery, including postoperative care.
- Are pregnant and undergoing treatment for pregnancy.
- Are/were determined to be terminally ill and are receiving treatment for such illness.

### **Health Care Cost Reporting**

Your health plan is currently engaged in solutioning and we continue to work with our Pharmacy Benefit Manager (PBM) to meet required reporting data elements for submission by December 27, 2022.

Self-insured clients with carve-out pharmacy benefits should work directly with their PBM.

## Mental Health Parity: Non-Quantitative Treatment Limitations

### Overview

On Dec. 27, 2020, H.R. 133 Consolidated Appropriations Act (CAA) became law. The Consolidated Appropriations Act, 2021 (CAA), Section 203, requires group health plans and issuers that cover mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits to prepare a comparative analysis of any nonquantitative treatment limits (NQTLs) that apply when explicitly requested by a state authority or federal secretaries, as applicable.

### What do employers need to know about the Consolidated Appropriations Act of 2021 (CAA)?

Many of the COVID-19 financial aid packages were set to expire at the end of the year. The Act aims to provide additional economic relief to industries, organizations, and individuals affected by the COVID-19 pandemic. Key provisions for employers include modifications to PPP loan forgiveness, a second round of PPP loans for the most impacted small businesses, extended and enhanced tax credits, and a final determination on the deductibility of expenses paid using PPP loan proceeds. The Consolidated Appropriations Act of 2021 (CAA) provides \$900 billion in aid and extends many of the provisions introduced under the CARES Act. Among provisions for individuals, such as direct cash to workers, rental assistance, and a ban on surprise medical bills, the CAA also enhances aid for small businesses and renews the Paycheck Protection Program. One of the requirements to this bill includes **group health plans and issuers that cover mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits to prepare a comparative analysis of any nonquantitative treatment limits (NQTLs) that apply when explicitly requested by a state authority or federal secretaries, as applicable.** NQTLs are non-numerical requirements that could limit the scope or duration of services for the treatment of a mental health or substance use disorder benefit, such as medical management, provider reimbursement, geographic and facility type limitations, etc.

### When is this effective?

Beginning Feb. 10, plans must supply this analysis and other information if requested by state authority or federal secretaries, as applicable (the Department of Labor [DOL] for ERISA plans).

### What is the intent?

In the face of a pandemic, access to mental health care and substance use disorder support is more critical than ever. Unlike many of the other provisions of the CAA that affect group health plans, the Mental Health Parity and Addiction Equity Act (MHPAEA) requirement went into effect on Feb. 10, 2021. This is clearly a priority — guarding access and removing barriers to mental health care.

### What is the objective?

To secure and bolster the MHPAEA and ensure that group health plans that provide mental health and substance use disorder benefits don't impose less favorable terms and conditions on MH/SUD benefits than on medical and surgical benefits.

**Is your health plan aware of the NQTL compliance disclosure set forth by the CAA?**

Yes, your health plan is aware of and continuously monitors for Federal and State guidelines regarding compliance metrics related to NQTL.

**Is your health plan compliant with the NQTL section of the CAA?**

Yes, your health plan will be able to provide the comparative analysis to the requesting regulator within the time parameters provided.

**Will your health plan assist self-insured clients with specific requests from regulators regarding the NQTL comparative analysis?**

Yes, your health plan will support each client when the official request from a regulator is received to ensure the requested information is provided in a timely fashion and will be available to assist the client/regulator with any subsequent follow-up questions.

**What happens if the regulator requests additional information regarding the NQTL analysis?**

Per the law, if the regulator requests additional quantitative analysis information after the initial submission, plans have an additional 45 days to provide said documentation. During that time frame, your health plan will assemble and provide the additional information requested and provide it back to the client prior to the submission deadline.

Your health plan will continue to issue updates as we work through all aspects of implementation.

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