BlueCross BlueShield of Montana

Update: Transparency in Coverage and Consolidated Appropriations Act

No Surprises Act (NSA): Surprise Billing

Note: The NSA is part of the Consolidated Appropriations Act. This section discusses key aspects of the NSA related to surprise billing, but is not a comprehensive review of all requirements in the law or regulations.

- **For plan years effective on or after Jan. 1, 2022**, providers will no longer be able to balance bill members for these services:
  - **Emergency services** – the legislation expands the definition of emergency services. We are updating our claims system to make changes that are needed to support the expanded definition
  - **Out-of-network (OON) care during in-network (INN) facility visit**
  - **OON air ambulance services** (if the plan would cover the services INN)

- Some providers may balance bill if the provider satisfies notice and consent requirements. Generally, the notice and consent requirements allow certain providers to balance bill a member if, in advance of receiving treatment, the provider has disclosed certain information and the member has agreed to receive out-of-network services. This option is not available to emergency or several other types of providers.

- The NSA requires payment directly to providers but does not require a specific amount that plans must reimburse providers on claims that are subject to the NSA. However, to the extent ASO accounts are currently reimbursing providers at or near billed charges to protect their employees from balance bills, those accounts may be considering adjusting their reimbursement approach because members will no longer be balance billed for many services.

- The NSA establishes a negotiation and the **independent dispute resolution (IDR)** process to resolve payment disputes.

  - Prior to initiating IDR, a provider and plan must try to negotiate a payment amount. In the event a negotiation does not resolve the claim payment, the plan or provider may initiate an IDR matter.
  - In IDR, the provider and the plan each present their payment offer and additional information about the claim to the IDR entity. The IDR entity chooses one of the offers as is, without any modifications.
  - The party that loses the IDR will be responsible for the IDR entity's fees. At this point, the amount of the fees are subject to additional guidance from the government.
  - The negotiation and IDR process are governed by strict timeframes and information requirements.

- Administrative fees for ASO accounts may be assessed as a per-claim cost for negotiation and IDR services provided by Blue Cross and Blue Shield of Montana (BCBSMT). ASO accounts will be charged for the IDR entity fees in the case of an IDR loss.

- BCBSMT may provide updated contract language to document group instructions related to NSA, the scope of our services in support of NSA, and any costs related to those services.

- Based on other surprise billing legislation within our states, we have established expertise and experience with processes similar to the new surprise billing requirements of the NSA, and we will leverage that expertise to implement solutions for our customers. Upon request, BCBSMT will discuss a financial review for some customer clients, particularly those paying at or near billed charges to OON providers.

- While BCBSMT may make financial reviews available upon request, BCBSMT makes no representation or warranty related to the costs or financial responsibility group customers or plans may incur related to the NSA. BCBSMT also does not provide any legal advice. The scope of the NSA and its requirements are subject to change and the effect on group plans will vary based on many factors. Any information provided by BCBSMT, including any financial analyses, is for illustrative purposes only and all benefit design decisions are the responsibility of the plan sponsor.

Consolidated Appropriations Act (CAA): Other Provisions

Gag Clauses

- Prohibits issuers and group health plans from entering into agreements with providers that include "gag clauses" related to provider-specific cost and quality data.
- The contract cannot prohibit issuers and group health plans from disclosing provider-specific cost or quality information to:
  - Referring providers
  - The plan sponsor
  - Members/individuals eligible to become members
- If any provider agreement or group contracts contain gag clause language, that language is considered unenforceable.
- Any identified gag clause language is being remediated.
- Effective immediately beginning **Dec. 27, 2020**

Broker and Consultant Compensation (Group)

- Requires anyone providing brokerage/consulting services to ERISA-covered group health plans to disclose to the plan all direct/indirect compensation received over $1,000 during the contract term.
- Applies to any contract entered into, extended or renewed on or after **Dec. 27, 2021**

Broker and Consultant Compensation (Retail)

- Generally, health insurance issuer offering individual health insurance coverage must make disclosure to enrollees during plan selection and enrollment.
- Applies to any contract entered into, extended or renewed on or after **Dec. 27, 2021**

Mental Health Parity (MHP)

- Requires plans and issuers to perform and document a **non-quantitative treatment limitation (NQTL)** analysis and make it available **upon request** to the applicable Tri-Agency Department or applicable State authority.
  - A plan's NQTLs must be in parity "as written" and "in operation."
  - There is no requirement to proactively disclose the analysis.
- Does not impact current MHP Financial or Quantitative Treatment Limitation (QTL) testing.
- Does not substantively change previous NQTL analysis guidance and provides very little additional guidance: no template has been provided and no further guidance is expected until 2022.
  - Almost no guidance exists regarding how to demonstrate parity "in operation" (also known as the "stringency" analysis)
- Groups can request an NQTL analysis demonstrating parity "as written."
- We discourage client-specific or plan-specific requests for stringency reports until further rulemaking is provided. Requests may result in an additional fee if there is insistence on providing a stringency report at this time.
- **Effective 45 days after enactment, Feb. 10, 2021**

Pharmacy Benefit and Drug Cost Reporting

- Group health plans or health insurance issuers must submit plan-related information in 10 categories from the previous plan year to the Tri-Agency Departments **no later than Dec. 27, 2021,** and no later than June 1 each year thereafter.

- Not later than 18 months after the first report is required, and biannually thereafter, the HHS Secretary will publish aggregated data on the HHS website to include:
    - Prescription drug reimbursements under group health plans and group/retail health insurance coverage
    - Prescription drug pricing trends
    - The role of prescription drug costs in driving premium increases or decreases under such plans or coverage
- CMS released a Request for Information (RFI); comments were due July 23, 2021.
- We expect additional rulemaking, but do not have a specific timeline.

Continuity of Care

- Requires Group/Retail insurers and ASO plans to provide continuity of care and transition benefits with certain providers.
- Plans must notify members of a provider termination and allow the member to request continuity of care benefits for 90 days for the following:
    - Treatment for a serious and complex condition
    - Institutional or inpatient care from the provider
    - Scheduled for nonelective surgery
    - Pregnancy or course of treatment for pregnancy
    - Terminal illness
- Patients can choose to continue services (under same plan coverage terms and conditions) for the earlier of:
    - The 90-day period beginning on the date the notice is provided, or
    - The date the member is no longer a continuing care patient with the specific provider/facility
- Network status changes include termination (except due to fraud or failure of the provider to meet applicable quality standards), change in network status, and plan changes resulting in loss of benefits with the provider
- The provider or facility must accept payment from the plan or issuer (plus applicable member cost share) as payment in full for such items and services and continue to adhere to all policies, procedures, etc.
- **Effective date: Plan years beginning on or after Jan. 1, 2022**

Transparency in Coverage (TIC) Final Rule & Transparency Provisions of the Consolidated Appropriations Act (CAA)

TIC: Cost-Sharing Estimator Tool

- Insurer/group health plans must provide members personalized cost-sharing estimates for covered items and services and other information upon request.
- The Cost-Sharing Estimator Tool is introduced in two phases:
    - Phase 1 will focus on 500 shoppable items and services with an effective date of Jan. 1, 2023.
    - Phase 2 will expand to cover all items and services with an effective date of Jan. 1, 2024.

CAA: Price Comparison Tool

- Insurers/group health plans must provide a price comparison tool that allows members to compare cost-sharing for services among different providers.
- **Effective date: Plan years beginning on or after Jan. 1, 2022**

2022 approach on the Price Comparison Tool

- BCBSMT is expanding on current cost transparency capabilities offered to members through Blue Access for Members℠, to all networks and products.
- We are also continuing to support integration with Axis National Cost Transparency data.
- Pricing data will be expanded to support the 500 shoppable services identified under the Transparency in Coverage Final Rule by **Jan. 1, 2022.**

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TIC: Machine-Readable Files

Insurers/group health plans must make available to the public three machine-readable files of:

- In-network rates – based on contracted rates for services
- Out-of-network allowed amounts – based on historic claims data
- Prescription drug rates and historical net prices
- **Effective date: Plan years beginning on or after Jan. 1, 2022**

2022 Approach on machine readable files:

- BCBSMT will make machine readable files available on a publicly accessible site.
- Pricing data is defined at the benefit plan level.
- Due to the size of the national PPO network, the in-network rate file will be published by state or region.
- We are working with Prime Therapeutics® on the creation of the prescription drug rate file with historic net prices, and will include this file for accounts that have pharmacy coverage through Prime.
- Prescription drug files containing negotiated rates for drugs covered under the medical policy will be provided for plans that carve out pharmacy coverage.
- **Fully insured business:** Files will be posted to a BCBSMT public website.
- **ASO business:** Final business decisions are still pending. We are reviewing options to post files for groups to download.

CAA: Advanced Explanation of Benefits (EOB)

- The Advanced EOB may be requested by a provider when a member makes an appointment for a service.
- The information included represents a good faith estimate, based on the information known at the time of the appointment.
- **Effective date: Plan years beginning or after Jan. 1, 2022**

2022 approach on Advanced EOBs:

- The requirements for Advanced EOBs are still in development and may be subject to further rulemaking from the government.
- BCBSMT will align with industry standards to simplify for providers and improve adoption.
- We expect to accommodate “bundled” provider information when the provider completing the Advanced EOB can supply, to provide the member with a comprehensive total for services.
- BCBSMT expects to encourage digital distribution to make information easier to access in a timely manner.
    - **Important pricing note**: The cost associated with Advanced EOB printing and mailing is one of the most significant pricing impacts of the CAA. Moving members to digital Advanced EOBs over the 2022 calendar year will decrease the cost. We are evaluating the best approach to move members to digital in 2022.
- The final rule may change the current implementation approach and timeline.

CAA: Provider Directory

Insurers/group health plans must have a process to:

- Verify and update provider directory at least every 90 days
- Changes to provider data must be reflected within two (2) business days
- Respond to member network questions within one (1) business day
- Establish a database for the directory
- Focus is on public directory
- **Effective date: Plan years beginning on or after Jan. 1, 2022**

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2022 approach on provider directories:

- A process will be established for quarterly verification of provider data
- BCBSMT is implementing procedures to increase the frequency of data updates, to support the two-business day turnaround time. For accounts who host their own provider finder leveraging provider data through the Blue Cross and Blue Shield Association, procedures may need to be put in place to increase the frequency of updates.
- Provider data that has not been verified may be removed from provider directories.
- Final rule may change current implementation approach and timeline.

CAA: Member ID cards

Requires physical or electronic ID cards to include:

- Any applicable deductible under the plan
- Any applicable out-of-pocket maximum under the plan
- Phone number and website for consumer assistance information (we currently support this on all Group and Retail ID cards)
- Information must be presented in clear writing
- **Effective date: Plan years beginning on or after Jan. 1, 2022**

2022 approach on member ID cards:

- Current plans with no changes will continue their approach as usual through the end of the year – members who haven't changed their plan won't receive a new physical card; those who make changes will.
- In most instances, except for accounts with different arrangements, plans with no changes will have all ID cards reissued digitally only at their 2022 renewal. Members can call to request a physical card at any time.
- A new physical card will be issued to members with plan changes or new enrollment.
- Accounts requesting a full reissuance of physical cards (outside of a plan change) may incur cost.
- **For ASO and fully insured accounts with custom logos/info on ID cards:** The information required under the CAA should not impact the current placement of account logos.
- We will work with groups that have additional customization requests to determine what can be accommodated on the printed card.
- We have already begun to see wide adoption of digital ID card information within the provider community and will develop communications to expand awareness and adoption of digital cards.