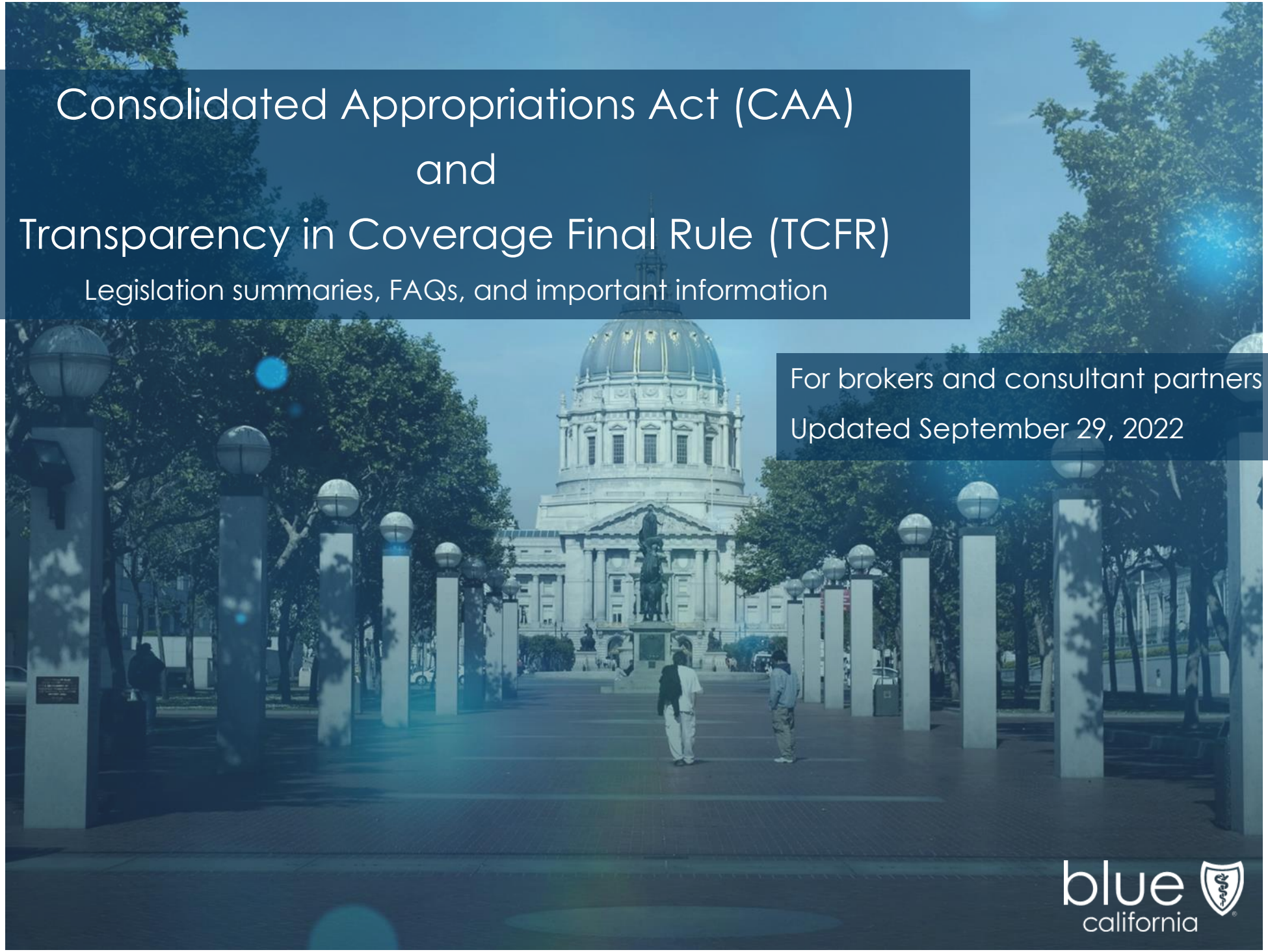
Consolidated Appropriations Act (CAA) and Transparency in Coverage Final Rule (TCFR)

Legislation summaries, FAQs, and important information



For brokers and consultant partners

Updated September 29, 2022

blue california

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Overview

This publication contains current information on regulatory developments, including summarized explanations of CAA's and TCFR's health care provisions, and answers to our most frequently asked questions.

Please note: This document is intended for informational purposes only. It is not considered a comprehensive summary of the mandates and is not legal or compliance advice. Employer groups and brokers should consult their own legal/compliance counsel with legal/compliance questions. Information may change based on developments in mandate requirements or guidance from regulatory agencies.

Consolidated Appropriations Act (CAA), 2021 Overview

Background

The Consolidated Appropriations Act (CAA)[1] of 2021 allocated more than $2 trillion. It funded the federal government through fiscal year 2021, supported a broad COVID-19 relief package, and stood up new consumer protection laws in the private health insurance market.

The CAA is among the largest and most impactful health laws since the Affordable Care Act (2010). It has the potential to reshape consumers' and providers' relationship to healthcare costs and change the landscape of health plan[2] compliance.

Provisions

- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Surprise Billing
- Continuity of Care

Transparency Provisions

- Broker/Consultant Compensation Disclosure
- Gag Clauses
- Pharmacy Benefits and Drug Cost Reporting
- Advanced EOB and Good Faith Estimate
- Provider Directories
- Insurance ID Cards
- Price Comparison Tools

Scope

CAA's Division BB, Title I: No Surprises Act and Title II: Cost Transparency contain most provisions that impact plans and providers. This legislation should be read alongside the Transparency in Coverage Final Rule (TCFR), which is summarized in the next section.

The provisions, which add considerable value for healthcare consumers, depend on significant development efforts by health plan operations, claims, and IT capabilities. In turn, development efforts depend on timely release of guidance and regulation from federal agencies. These dependencies are most evidenced by the Department of Labor's August 2021 FAQs and concurrent enforcement deferrals of several CAA provisions.[3]

Market Impacts

CAA governs individual and group commercial health plans, and certain other ERISA health plans. Exceptions do apply and California law impacts must be considered. These instances will be noted as applicable. CAA does not impact Medicare, including Medicare Supplement plans, Medi-Cal (Medicaid), or Medicaid-Medicare plans (MMPs).

Characteristics	CAA Applicability
Individual & family plans (IFP)	✓ on-exchange and off-exchange ✓ grandfathered and non-grandfathered
Group plans	✓ small group ✓ large group & custom ✓ trusts & associations ✓ federal employee plans (FEP)
Plan type & design	✓ medical plans, with or without embedded dental and vision ✓ HMO, PPO, POS, EPO, POS, PSP, FEH-BP
Funding	✓ fully-funded, self-funded, flex-funded ✓ fully-insured, self-insured, hybrids

1 Consolidated Appropriates Act, H.R 133, Division BB (2021).

2 *Health plan* will be used interchangeably with *carrier*, *payer*, and *issuer* in this document unless otherwise indicated

3 FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation part 49.

Regulators

The "Tri-Agency", consisting of the U.S. Departments of Labor (DOL), Treasury (IRS), and Health and Human Services (HHS), is developing regulations and providing guidance on CAA implementation and enforcement.

The Tri-Agency developed TCFR guidance as well. TCFR enforcement activities will be conducted by the Tri-Agency and state insurance regulators.

Transparency in Coverage Final Rule (TCFR) Overview

Background

The Transparency in Coverage Final Rule (TCFR) followed a 2019 executive order called *Improving Price and Quality Transparency in American Healthcare to Put Patients First*.[4]

The Final Rule gives consumers and stakeholders access to health care pricing information to support informed decision-making by patients and enable innovations and competition in the health care industry.

Publicly available pricing information is likely to have many upstream and downstream impacts on negotiated rates and the way in which these rates are negotiated. In addition to expected changes in the cost of certain services, value is also another factor likely to receive increased attention.

Components

- Cost Sharing Estimator
- Machine Readable Files
- Medical Loss Ratio

Regulators

The "Tri-Agency": Department of Labor (DOL), Department of the Treasury (IRS), U.S. Department of Health and Human Services (HHS) is providing guidance and regulations as they develop.

The Tri-Agency developed CAA guidance as well. Enforcement activities will be conducted by the Tri-Agency and state insurance regulators.

Market Impacts

TCFR requirements span individual and group commercial health plans. Exceptions do apply and California law impacts must be considered. These instances will be noted as applicable. TCFR does not impact Medicare, including Medicare Supplement plans, Medi-Cal (Medicaid), or Medicaid-Medicare plans (MMPs). TCFR does not apply to grandfathered health plans.

Characteristics	CAA Applicability
Individual & family plans (IFP)	✓ on-exchange and off-exchange ✓ non-grandfathered
Group plans	✓ small group ✓ large group (Core and Premier)
Plan type & design	✓ medical, dental, vision, and pharmacy ✓ HMO, PPO, POS, EPO, POS, PSP
Funding	✓ fully-insured, flex-funded, self-funded (ASO/Shared Advantage)

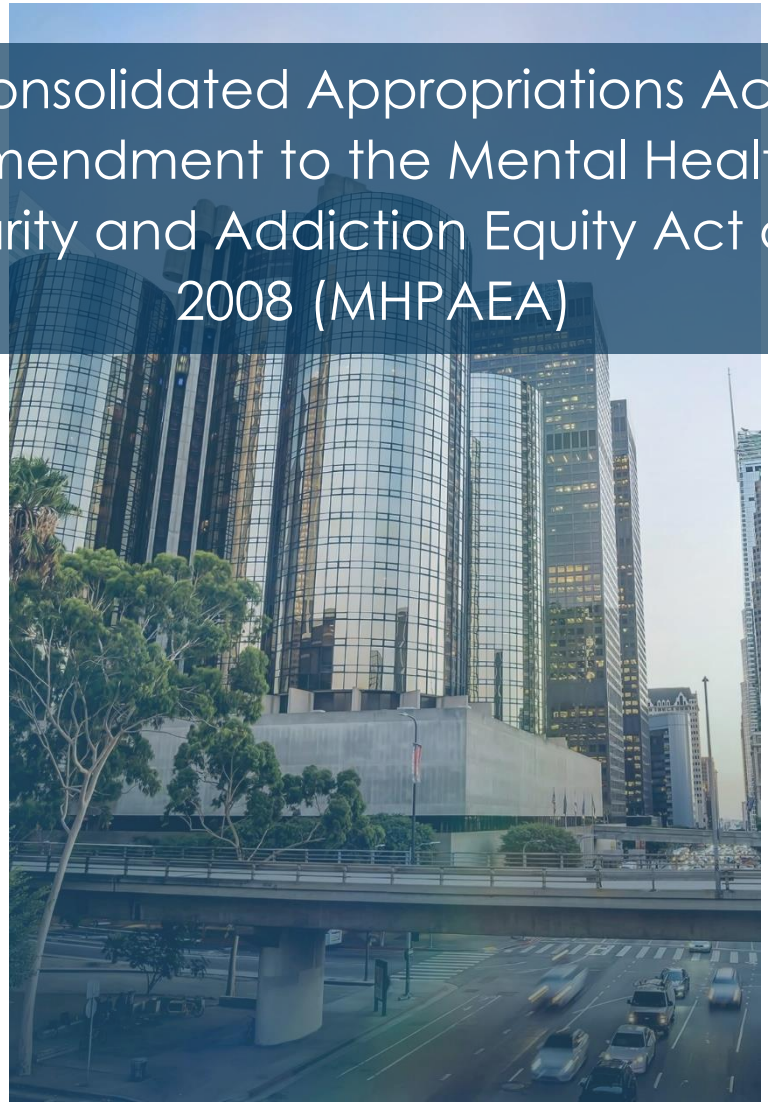
4 Improving Price and Quality Transparency in American Healthcare To Put Patients First, E.O. 13877 (Jun 24, 2019)

Blue Shield Compliance Plan

Legislation/ Provision	Effective Date	Details
CAA – Mental Health Parity and Addiction Equity Act	**2/10/21**	Blue Shield will provide a comparative analysis, for eligible groups, describing selected nonquantitative treatment limitations (NQTLs) and the comparative analysis required to supporting the application of those NQTLs to MH/SUD benefits upon request through your Account Manager.
CAA – Surprise Billing	**1/1/22**	Under this provision, members are only responsible for in-network cost-sharing amounts for out-of-network services rendered in certain scenarios outlined by the law. The provision also outlines an Independent Dispute Resolution (IDR) process for out-of-network billing disputes if providers and health plans are unable to reach an agreement on an out-of-network Qualifying Payment Amount (QPA). Blue Shield is aware of the IDR process and is prepared to comply with the requirements set forth by the Centers for Medicare and Medicaid Services (CMS) in the case it must partake in an IDR with a provider.
CAA – Continuity of Care	**1/1/22**	Blue Shield is consistently identifying impacted members who qualify for continuity of care protections and is notifying them of the option to continue transitional care from that provider. A member can request continuity of care by visiting blueshieldca.com and filling out the Continuity of Care Application. Please view the Request for Continuity of Care Services document for more details.
CAA – Transparency: Broker/Consultant Compensation Disclosure	**12/27/21**	To comply with the disclosure requirement for Individual & Family Plans, Blue Shield's applications and enrollment materials will now include verbiage disclosing information on broker compensations. Blue Shield has no disclosure obligation for employer-sponsored group health plans.
CAA – Transparency: Gag Clauses	**12/27/20**	Blue Shield values transparency for our members, providers, and plan sponsors and is compliant.
CAA – Transparency: Pharmacy Benefits and Drug Costs Reporting	**First reports due 12/27/2022; following reports due 6/1 of every year thereafter**	Blue Shield is preparing to submit data files as required by this provision for reports due by December 27, 2022. Some groups with either pharmacy or stop loss carved out will be responsible for submitting certain data elements. A detailed matrix of reporting responsibilities can be found here.

Legislation/ Provision	Effective Date	Details
CAA – Transparency: Advance EOB and Good Faith Estimate	**Pending further rulemaking**	The Tri-Agencies announced deferred enforcement of this requirement until further rulemaking due to a need for more information on the standards for data transfers between providers and health plans. Blue Shield project teams continue to work on all other unimpacted requirements and await further guidance.
CAA – Transparency: Provider Directories	**1/1/22**	Blue Shield is compliant with the Provider Directories requirements. This includes a protocol to respond to member network questions within one business day, and that members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing. Members can find the most up to date provider information using the Blue Shield *Find a Doctor* tool or by calling the Customer Care number on their Blue Shield member ID card.
CAA – Transparency: Insurance ID Cards	**1/1/22**	Blue Shield is compliant. We included required information on member ID cards and reissued ID cards to all members upon enrollment or renewal in a 2022 plan.
CAA – Transparency: Price Comparison Tools	**1/1/22**	The requirements for CAA price comparison tool overlap with that of TCFR cost sharing estimator tool. The Tri-Agencies have acknowledged this and announced deferred enforcement until further rulemaking.
TCFR – Price Comparison Tools and Cost Sharing Estimator Tool	**1/1/23** - 500 services **1/1/24** - all services	The requirements for CAA price comparison tool overlap with that of TCFR cost sharing estimator tool. The Tri-Agencies have acknowledged this and announced deferred enforcement until further rulemaking.
TCFR – Machine Readable Files (MRF)	**7/1/22**	Blue Shield has posted required data files under the Machine Readable Files (MRF) provision. These files are hosted through an external vendor and available through this link: Blue Shield of California – Machine Readable Files Blue Shield has addressed the compliance obligation of this provision as it applies to our fully-insured group plans. Self-funded group plan sponsors need to post this link on their own websites for compliance purposes. It is up to the self-funded plan to determine where on its site to publish this link, but the link must be publicly available (no login or other requirements should be required to access the MRF files). A webpage for MRF, publicly available to anyone visiting the Blue Shield home page, is available here.
TCFR – Medical Loss Ratio	**7/31/21** 2020 reporting year	The Affordable Care Act (ACA) requires health plans to spend a minimum percentage of plan members' premium on medical expenses, known as the "Medical Loss Ratio" or the "80/20 rule". Blue Shield does not owe MLR rebates for 2021 since Blue Shield met or exceeded the MLR targets for IFP, SBM, and Large Group. As a result, no MLR rebates will be issued for 2021 plans.

Consolidated Appropriations Act: Amendment to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)



CAA: Mental Health Parity and Addiction Equity Act (MHPAEA)

H.R. 133, Division BB, Title I, § 203

Background

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires that group health plans and issuers that provide Mental Health and Substance Use Disorder MH/(SUDs) benefits maintain parity between medical and surgical (M/S) benefits and mental health and substance use disorders (MH/SUD) benefits. This parity is required for financial and quantitative treatment limitations (QTLs) such as copays, deductibles and visit limits and for non-quantitative treatment limitations (NQTLs). NQTLs are limitations or restrictions on benefits that are not numerically based. Examples of NQTLs include utilization management; prescription drug formulary design; provider network participation, credentialing, and reimbursement rates.

Effective Date

February 10, 2021

Market Impacts

LOB: IFP, SG, Core, Premier

GF Status: Grandfather, Non-Grandfather

Exchange: On Exchange, Off Exchange

Medical Plans: HMO, PPO, EPO, POS, PSP, FEH-BP*

* FEH-BP is a federal plan sponsored by OPM. As this is a local plan by design, and benefit administration is similar to commercial HMO, FEH-BP is in-scope for this legislative update.

Funding: Fully-insured, Flex-funded, Self-funded

Requirements do not apply to:

- Medicare Advantage, Med-Supp, Cal Medi-Connect,
- Stand-Alone Dental, Stand-Alone Vision or Life

Requirements

The Consolidated Appropriations Act of 2021 (Section 203) amends the Mental Health Parity and Addiction Equity Act (MHPAEA) to require group health plans and issuers of individual or group health insurance coverage to perform and document comparative analyses of all of the NQTLs applicable to their MH/SUD benefits. The MHPAEA previously required that NQTLs applicable to MH/SUD benefits be comparable and applied no more stringently than those applied to M/S benefits, but this comparative analysis requirement for NQTLs is new. Previously, California state regulators reviewed NQTL parity, but until recently, Blue Shield has not been required to provide the detailed written comparisons or data analytics required under Section 203 of the CAA as demonstration of NQTL parity.

Compliance

Plans must report their NQTL analyses to the DOL, HHS, or other applicable regulatory agencies upon the agency's request. The report must:

- define each NQTL and the benefits to which it is applies;
- discuss "factors and standards" used to determine the application of the NQTL; and
- demonstrate MHPAEA compliance via the application of any NQTL to MH/SUD benefits.

The report must be furnished within 45 days.

Corrective Action Plan

If a plan cannot demonstrate compliance, the requesting agency may require a corrective action plan.

Notice

If compliance cannot be achieved using the corrective action plan, a plan/insurer may be required to notify enrollees of its failure to comply.

Operational Requirements

Plans/insurers must develop policies and procedures describing the MHPAEA NQTL comparative analysis process for utilization management (UM), and non-UM operations, such as credentialing, provider contracting, and provider reimbursement.

Federal regulators will issue compliance program guidance and update it every two years thereafter.

Regulations pending.

Frequently Asked Questions - General

1. **What is The Consolidated Appropriations Act, 2021 (the "Act")?**
   The Consolidated Appropriations Act, 2021 (the "Act") was signed into law on December 27, 2020. The Act combines the $1.4 trillion omnibus federal spending package for the 2021 fiscal year and a $900 billion COVID-19 stimulus package.

2. **What is the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)?**
   The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is federal law that requires group health plans and issuers that provide mental health and substance use disorder (MH/SUD) benefits, to provide those benefits in parity with medical and surgical
   (M/S) benefits. Parity is required for financial and quantitative treatment limitations (QTLs) such as copays, deductibles and visit limits and for non-quantitative treatment limitations (NQTLs). NQTLs are limitations or restrictions on benefits that are not numerically based. Examples of NQTLs include utilization management; prescription drug formulary design; provider network participation, credentialing, and reimbursement rates.

3. **What are the requirements of Section 203 - Mental Health and Substance Use Disorder (SUDs) benefits?**
   Section 203 amends the Mental Health Parity and Addiction Equity Act (MHPAEA) to require group health plans and issuers of individual or group health insurance coverage to perform and document comparative analyses of all of the NQTLs applicable to

their MH/SUD benefits, and report to the state or federal regulators upon request.

4. **What is the effective compliance date of Section 203?**
   Beginning February 10, 2021, Section 203 requires health plans to make available a comparative analyses of nonquantitative treatment limitations (NQTLs) to state and/or federal regulators, upon request.

5. **For Section 203 requirements, how do plans and issuers demonstrate parity in the application of NQTLs to mental health and substance use disorder (MH/SUD) benefits and medical and surgical (M/S) benefits?**
   We demonstrate parity by looking at the factors and standards that are relied upon to create the NQTL and then showing that the NQTL in operation is not applied more stringently to the MH/SUD benefits when compared to the M/S benefits.

6. **What are Nonquantitative Treatment Limitations (NQTLs)?**
   Nonquantitative Treatment Limitations (NQTLs) are non-financial treatment limitations, such as prior authorization, concurrent/ retrospective review, provider credentialing, network participation, provider reimbursement that may limit the scope or duration of a benefit, or access to the benefit.

7. **When must plans make comparative analyses available to state and/or federal regulators?**
   Comparative analyses must be made available to state and/or federal regulators, upon request, within 45 days of enactment of the CAA.

8. **What must the comparative analyses include?**
   The comparative analysis must include definitions of each NQTL and the benefits it applies to, the factors and standards used to determine the application of the NQTL, and applicable data analytics demonstrating that the application of any NQTL to MH/SUD benefits complies with MHPAEA.

9. **Do California state regulators currently review NQTL parity? Yes.**
   California state regulators currently review NQTL parity, but until recently, Blue Shield has not been required to provide the detailed written comparisons or data analytics required to demonstrate NQTL parity for NQTLs under Section 203.

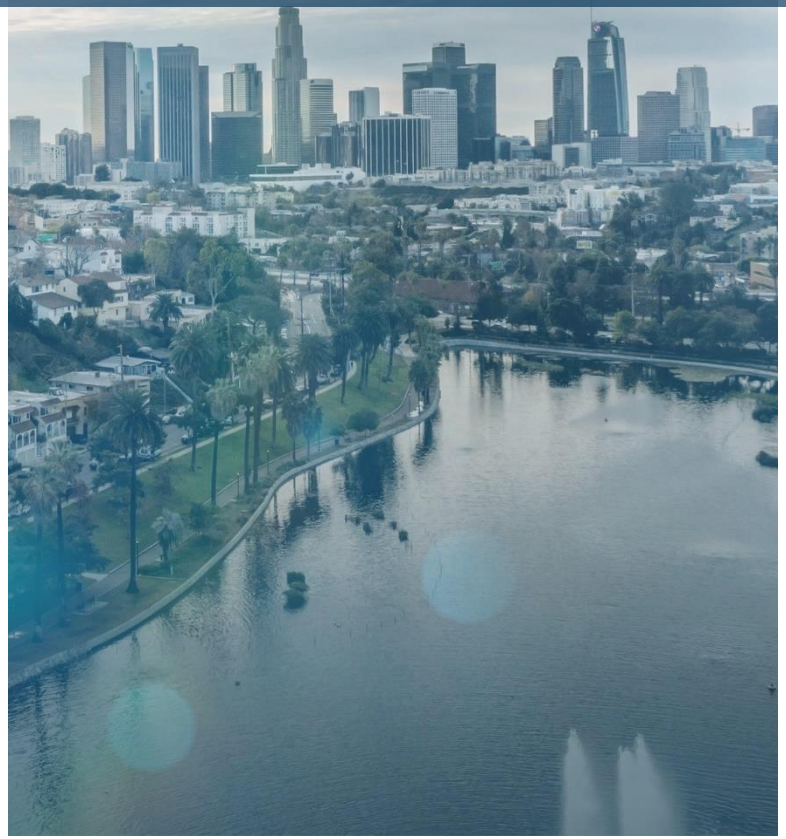
10. **Which Federal Agency has primary MHPAEA enforcement authority over employer sponsored group health plans?**
    The Department of Labor (DOL) has primary MHPAEA enforcement authority over employer sponsored group health plans.

11. **Which Federal Agency has primary enforcement authority over fully insured products offered in the group and individual markets?**
    Health and Human Services (HHS) has primary enforcement authority over fully-insured products offered in the group and individual markets.

12. **What role does the Department of Managed Health and the Department of Insurance have in the enforcement of MHPAEA Section 203?**
    HHS delegates enforcement authority over fully-insured products offered in the group and individual markets to state regulators.

13. **How can groups obtain a comparative analysis when?**
    Should any of your groups undergo audit by the Department of Labor (DOL) or require the comparative analysis, please reach out to your account service representative.

Consolidated Appropriations Act: Surprise Billing



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CAA: Surprise Billing

H.R. 133, Division BB, Title 1, § 102

Background

The No Surprises Act is designed to protect consumers from certain unanticipated out-of-network medical bills.

In particular, surprise billing provisions are intended to prevent health plans and providers from billing patients more than in-network cost-sharing amounts incurred at hospitals, facilities, individual practitioners, and air ambulance providers in certain emergency, and non-emergency situations.

Effective Date

January 1, 2022

Market Impacts

Does not apply to embedded pharmacy benefits, stand-alone dental and vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

Services impacted by Surprise Billing rule

CAA includes the following as "surprise medical bills":

- *charges for certain ancillary services provided by out-of-network providers at in-network facilities, and*
- *out-of-network care provided at in-network facilities without a patient's informed consent.*

When a patient is charged out-of-network rates that qualify as surprise bills, the CAA requires plans to apply out-of-network rates charged, towards the patient's in-network deductible and out-of-pocket maximum, in addition to reimbursing the difference in fees.

Emergency Services

Group health plans, or issuers offering group or individual coverage must cover emergency services without prior authorization, regardless of whether the provider or facility is in-network. Applying more restrictive requirements or cost-sharing to out-of-network emergency facilities or providers is prohibited.

Surprise billing protections apply to services administered in an emergency department or in a freestanding emergency department, if the plan or issuer covers any benefits with respect to emergency services. Cost-sharing must be calculated as if the services were provided by an in-network participating provider.

Accessing services from an out-of-network provider at an in-network facility with written **notice and consent**

The provider must send a notice to the plan that

acknowledges

- ✓ *the provider is out-of-network*
- ✓ *using an in-network provider could limit cost sharing responsibility*
- ✓ *whether prior authorization is required*
  - *encloses*
- ✓ *a list of participating providers at the facility who could provide the service*
- ✓ *a **good faith estimate** of charges the enrollee is likely incur for the provider's services*

Timing requirements

72 hours prior to when services are scheduled. If fewer than 72 hours remain, the provider must send notice to the plan on the same day the appointment is made.

Non-emergency Services

Under the No Surprises Act members are protected from surprise billing for non-emergency services performed by an out-of-network provider at an in-network facility when the provider does not follow a notice and consent process.

Determining the amount due on a "surprise bill"

The health plan must send initial payment or a notice of denial of payment within 30 calendar days of receiving a provider's or facility's bill for services covered by the law.

The in-network cost-sharing for an out-of-network provider would be determined by the "qualifying payment amount." Payment must go directly to the provider or facility.

Cost-sharing paid by members must count towards the in-network deductible and out-of-pocket maximum, as if the service had been provided in-network.

Dispute resolution requirement

CAA surprise billing reforms require plans and providers who cannot otherwise settle billing disputes to participate in an arbitration/independent dispute resolution (IDR) process.

The arbitration process is "baseball-style" –each side submits an offer, and the IDR entity selects one. Offers are due within 10 days of choosing an IDR entity, which has 30 days to select an offer.

Frequently Asked Questions – General

1. **What is surprise billing?**
   Surprise billing is when a patient unknowingly receives care from an out-of-network provider and has to pay for the majority or all of the costs for the service rendered. This scenario is most common during emergencies, when a patient is unable to choose an in-network facility or provider or, when the scheduled service received is performed by a care team that includes an ancillary out-of-network provider.

2. **Do all states have Surprise Billing laws in place?**

As of 2020, thirty-two states had surprise billing laws, however, specific protections vary by state.

3. **Does California have Surprise Billing protections in place?**
   Members enrolled in plans that are regulated under the State of California law, are protected from Surprise Billing when:
   - Treatment is received by out-of-network providers at an in-network facility without the member's written consent
   - Transportation by out-of-network air ambulances

   In the above scenarios, members cannot be charged anything above their in-network rates.

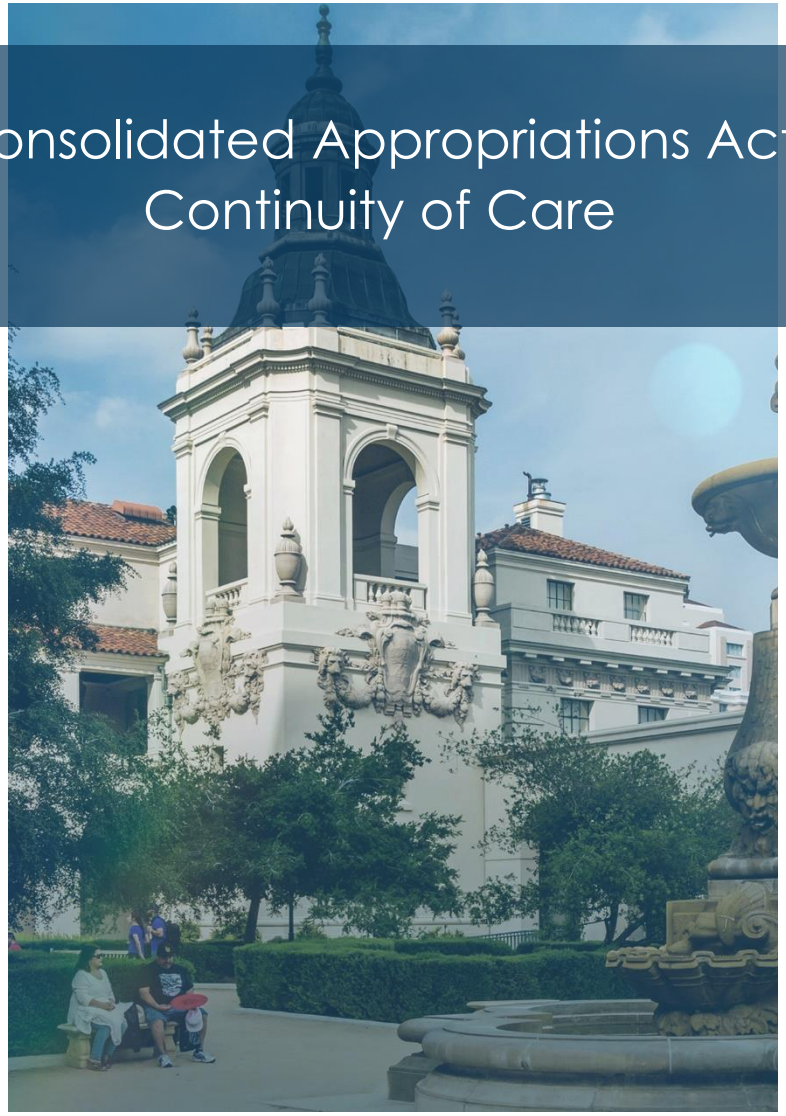
4. **What does the No Surprises Act of the CAA entail?**
   There are two main components of the No Surprises Act which will protect members from unexpected costs (during an emergency, or when the scheduled service received is performed by a care team that includes an ancillary out-of-network provider):
   - Insurers are required to reclassify out-of-network care as in-network when it comes to a member's financial obligation
   - Providers are prohibited from balance billing patients (billing at a rate higher than the in-network rate for out-of-network services)

5. **Which LOBs are impacted by the No Surprises Act?**
   Commercially insured members, including those enrolled in individual, group fully funded, and group self-funded plans are in-scope for the provision.

6. **What does the second rule issued by the Biden Administration implementing the surprise billing reforms in the No Surprises Act of the CAA entail?**
   On September 30, 2021 the Biden Administration issued a second rule implementing the surprise billing reforms in the No Surprises Act of the CAA. This provides information on the independent dispute resolution (IDR) process for out-of-network billing disputes between providers and health plans on reaching an agreement for out-of-network rates.

   The interim final rule details the federal arbitration / independent dispute resolution process that providers, facilities or providers of air ambulance services, and health plans will use to determine final payment beyond allowable patient cost-sharing for certain out-of-network healthcare services in situations where the No Surprises Act prohibits surprise billing. The rule also requires that certain providers and facilities provide a good faith estimate of the charges to uninsured (or self-pay) individuals so they can know what costs to expect when seeking healthcare.

Consolidated Appropriations Act: Continuity of Care



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CAA: Continuity of Care

H.R. 133, Division BB, Title 1, § 113

Background

Continuity of Care (CoC) requires continuation of care for patients in the middle of serious and complex care when their in- or out-of-state provider's contract ends, employer group health plan changes, or employer group health plan is terminated. In these scenarios, members have the option to continue receiving care for 90 days or until the treatment concludes, whichever is sooner.

Effective Date

January 1, 2022 for individual and family plans (IFP) and new group plans and on or after January 1, 2022 (upon renewal) for renewing groups.

Market Impacts

This provision *does* apply to self-funded, jointly administered group plans. It does *not* apply to dental, vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

Continuing care patients may continue receiving treatment for pregnancy, a serious and complex condition*, or a terminal illness in the following circumstances:

1. Provider terminates from the network, including out-of-state providers.
2. Employer Groups terminate their BSC plans.
3. Employer Groups change network offerings.

Providers must continue care until treatment ends or after 90 days, whichever is sooner and must accept payment, follow policies and procedures, and meet quality standards as if the expired contract were still in place.

*Please see FAQ #5 for more details.

Continuity of Care in California

Federal requirements for continuity of care, which are stricter than California's, must be incorporated into existing operations. Self-funded employer groups are not mandated to provide California CoC completion of covered services. However, employers may elect to offer *both* Federal and California CoC benefits. For more information, see FAQ #10 below.

Compliance

Health plans must notify members who qualify to continue care when a provider's network status changes, whether in- or out-of-network, or there is a change in their employer sponsored plan. The notice must describe how to apply for continuation of coverage and elect transitional care.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Continuity of Care provision?**
   Blue Shield is consistently identifying impacted members who qualify for continuity of care protections and is notifying them of the option to continue transitional care from that provider.

2. **What was the go-live date for Continuity of Care requirements?**
   The federal CoC benefits mentioned here are effective for plan years beginning on or after January 1, 2022. This means federal CoC laws were effective for new group plans and for individual and family plans (IFP) on January 1, 2022, and for renewing group plans upon renewal, on or after January 1, 2022.

3. **What kinds of Market Segments are impacted?**
   In scope: IFP, Small Business, Large Group On and Off Exchange; Self-Funded and Joint Administered Group plans.
   Out of Scope: Dental, Vision, or Life insurance plans. CAA does not impact Medicare, including Medicare Supplement plans, Medi-Cal (Medicaid), or Medicaid-Medicare plans (MMPs/ CMC (BSC Promise CMC)).

4. **What are the qualifying scenarios for CoC?**
   - Provider terminates from the network, including out-of-state providers.
   - Employer Groups terminate their BSC plans.
   - Employer Groups change network offerings.

5. **Who is qualified to enroll in federal CoC benefits? How will a member know if they qualify?**
   If a member's provider is no longer available, Blue Shield or their Mental Health Service Administrator (MHSA) will notify the member of the option to continue treatment with the member's former Participating Provider. A member can request continuity of care by visiting blueshieldca.com and fill out the Continuity of Care Application.

   An enrollee qualifies as an eligible individual for Continuity of Care if he or she is receiving care from a network provider for a/an:
   a) Acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
   b) Chronic illness or condition that is (i) life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.
   c) Course of institutional or inpatient care from a provider.
   d) Nonelective surgery from the provider, including receipt of post-operative care with respect to a surgery.
   e) Pregnancy and is undergoing a course of treatment for the pregnancy, or
   f) Terminal illness and is receiving treatment for such illness from a provider.

6. **What is a serious or complex condition?**
   Serious and Complex Condition: the term means, with respect to a participant or beneficiary under a group health plan or group health insurance coverage:
   a) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b) in the case of a chronic illness or condition, a condition that—
c) is life-threatening, degenerative, potentially disabling, or congenital; and
d) (ii) requires specialized medical care over a prolonged period of time.

7. **How will claims be paid? How does a member pay the claim as per previous contract rate?**
   Claims are processed at the in-network benefit.

8. **How can a past claim be rectified once CoC is approved?**
   A member requests adjustment through Customer Service. Customer Service will route adjustment request to claims for processing.

9. **What are the differences in the federal vs. California CoC?**
   The federal requirements are stricter than California requirements, as mentioned. In some cases, federal law extends CoC coverage throughout the course of treatment while California law puts a cap on the duration of treatment. Please refer to this chart to compare the two sets of CoC requirements. Self-funded employers may elect to offer state CoC offerings.

10. **Why would self-funded employers opt into the state CoC in addition to the federally mandated offerings?**
    Self-funded employers are not mandated to provide state CoC offerings as they are federally regulated. Self-funded groups may elect to include state mandates for a variety of reasons: the company may offer a fully-insured product (like an HMO) alongside the self-funded PPO and would like parity for their membership, or some employers are newly moving off a full-insured plan and choose to mirror the previous offerings to avoid member abrasion. Blue Shield offers employers to enroll in both state and federal mandates as part a commitment to providing flexibility and customization for self-funded clients.

11. **Will Blue Shield of California provide CoC coverage for groups transitioning to Blue Shield from another carrier?**
    No. We do not provide run-in services, where Blue Shield covers CoC costs for groups joining Blue Shield. Those costs would be the responsibility of the previous plan. We do offer run-out CoC services, allowing groups to continue with their doctor or treatment plan after leaving Blue Shield.

Consolidated Appropriations Act: Broker/Consultant Compensation Disclosure

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CAA: Broker/Consultant Compensation Disclosure

H.R. 133, Division BB, Title 1, § 202

Background

Section 202 creates broker compensation disclosure requirements for health insurance brokers on the individual market, and brokers and consultants who sell any type of group health plan.

Lawmakers based CAA broker compensation disclosure requirements in ERISA section 408(b)(2), which requires disclosure of broker investment fees charged to a retirement plan. The broad intent of both laws is to increase consumer transparency around plan fee structures and promote fair pricing.

Effective Date

December 27, 2021: All contracts executed on or after that date must comply. The requirement is not retroactive.

Market Impacts

Individual market disclosure requirement impacts IFP plans, including standalone dental and vision products, short term medical plans, and term life insurance.

The provision requirements does not apply to jointly administered self-funded plans, and pharmacy plans.

For additional details, please see general market impacts for CAA.

Requirements

IFP Market Broker disclosure and reporting

Plans on the individual market will disclose to members direct and indirect broker compensation paid in connection with enrolling members in a plan.

Group disclosure and reporting

Brokers, consultants, and any third-party administrator who receive compensation in connection with member enrollment must disclose to plan fiduciaries any direct and indirect compensation valued at more than $1,000.

Compliance

For individual plans, plans must disclose broker compensation in a member communication prior to the confirmation of enrollment, and in any document confirming enrollment. Plans must also report on broker fees to HHS each year prior to open enrollment.

Group plans, not regulators, must receive disclosures of broker fees and commissions several times during the contract's life cycle. If compensation is not disclosed, groups must report the failure to disclose. Liability stays with the group.

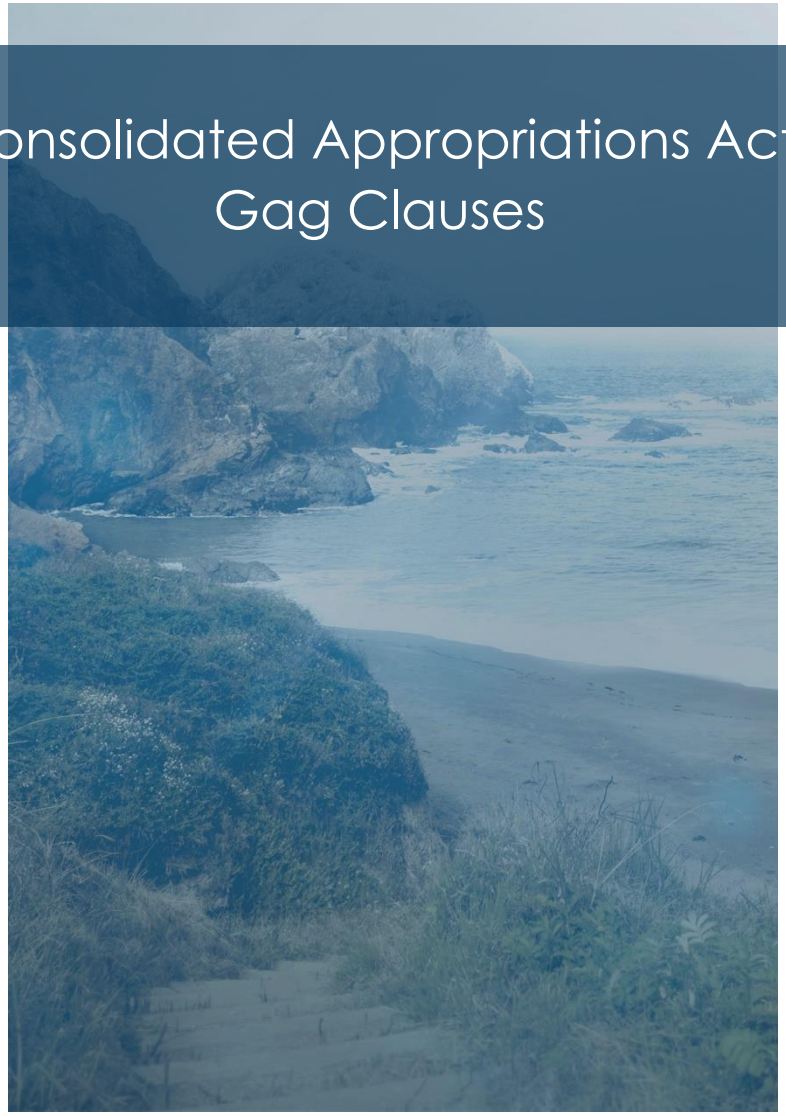
This provision takes effect on December 27, 2021, but full enforcement is deferred until final regulations are published. Until then, plans are expected to make a good faith effort to comply.

The agencies distributed draft regulations in September. The draft suggests potential placements of the disclosure, and regulations that will require extensive compensation records and analysis.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Broker/Consultant Compensation Disclosure provision?**
   To comply with the disclosure requirement for Individual & Family Plans, Blue Shield's applications and enrollment materials will now include verbiage disclosing information on broker compensations. Blue Shield has no disclosure obligation for employer-sponsored group health plans.

Consolidated Appropriations Act: Gag Clauses



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CAA: Gag Clauses

H.R. 133, Division BB, Title 1, § 201

Background

Gag clauses are not permitted in contracts between providers and health plans. The provision will enable a freer flow of provider pricing and quality data between the plan and its contractors.

Effective Date

December 27, 2020

Market Impacts

The requirements of this provision do not apply to standalone dental, vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

Group plans are not permitted to enter into contracts with providers that directly or indirectly restrict the plan from

1. sharing financial information with referring providers, such as service codes, the allowed amount, or any other claim-related financial obligations included in the provider contract.
2. accessing and sharing de-identified, HIPAA-compliant member and beneficiary claims and encounter data.

Compliance

Rules for how to implement the gag clause prohibition are not expected or necessary.

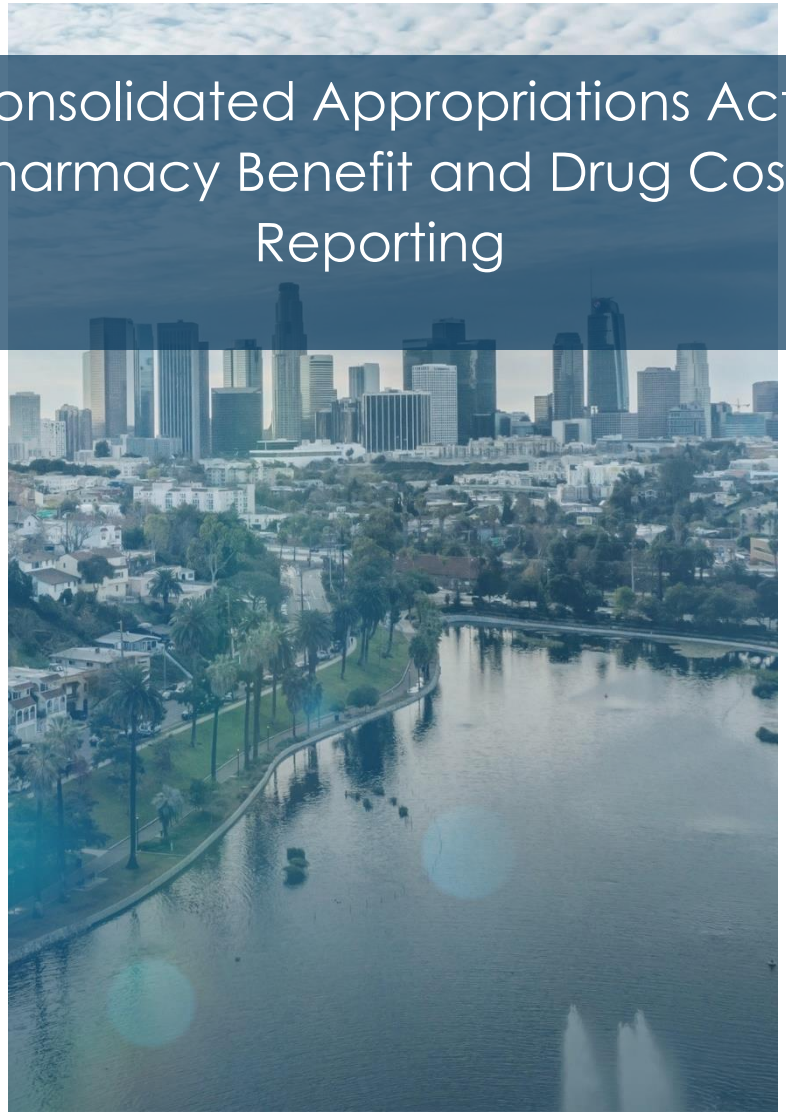
A health plan must submit an attestation of compliance to the Secretary of the U.S. Department of Health & Human Services (HHS). Guidance for how to submit the attestation is forthcoming.

Regulators expect to begin collecting attestations in 2022.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Gag Clauses provision?**
   Blue Shield is compliant with the requirements of this provision. We value transparency for our members, providers, and plan sponsors and are committed to prioritizing this.

Consolidated Appropriations Act: Pharmacy Benefit and Drug Cost Reporting



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CAA: Pharmacy Benefit and Drug Cost Reporting

H.R. 133, Division BB, Title 1, § 204

Background

Health plans and group plan sponsors are required to report on certain medical costs and prescription drug spending.

The Tri-Agency will use pricing data provided from plans to develop a report on prescription drug pricing trends and their contribution to health insurance premiums. The report will be published on the agencies' websites.

Effective Date

First reports, for reference years 2020 and 2021, are due on December 27, 2022. Following reports are due by June 1 of every year, including reports for year 2022 due June 1, 2023.

Market Impacts

LOB: IFP (On- and Off-Exchange), Small Business, Large Group (Core and Premier)
Grandfathered Status: Grandfathered and Non-Grandfathered
Funding Type: Fully-Insured, Flex-Funded, Self-Funded (ASO/SA)
Plan Type: Pharmacy
Product Type: HMO, PPO, POS, PSP, FEP, FEBHP, Student Health

For additional details, please see general market impacts for CAA.

Requirements

Health plans and group plan sponsors are required to report certain information on prescription drug coverage and health care costs to the Center for Medicare & Medicaid Services (CMS) as outlined below. Reports for reference year 2020 & 2021 are due on December 27, 2022. Reports for reference year 2022 are due on June 1, 2023 and annually thereafter.

Below is a summary of the data elements required for reporting:

1. P2 Group Health Plan List

The plan list identifies all the plans submitting any data. The plan lists consists of plan level information such as the beginning and end dates of the plan year, the number of members, and the states in which the plan or coverage is offered. For example, if Blue Shield, the group plan sponsor, and the carve out carrier are submitting any data elements D1-D8, each entity must also submit P2.

2. D3 Top 50 Most Frequent Brand-Drugs

The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid, the total number of paid claims in the aggregate, and the total number of paid claims individually

3. D4 Top 50 Most Costly Drugs with respect to the Plan or Issuer

- *by total annual spending*
- *annual amount spent on each individual drug*

4. D5 Top-50-Drugs-by-Spending-Increase with respect to the greatest increase in plan expenditures

- *over the plan year preceding the plan year that is the subject of the report*
- *for each such drug individually, the change in amounts expended by the Plan or Issuer in each such plan year.*

5. D6 Rx-Totals: Total spending on health care services by such Plan or Issuer, broken down by

- *type of health care costs*
- *pharmacy Rx costs*
- *monthly premiums paid by employers and by enrollees.*

6. D7 Rx-Rebates-by-Therapeutic-Class with respect to prescription drugs prescribed to enrollees in the Plan or issued coverage, any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the Plan or Issuer or its administrators or service providers

7. D8 Rx-Rebates-for-the-Top-25-Drugs with respect to any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration.

Compliance

Please refer to the reporting responsibilities matrix for reporting responsibilities by market segment/line of business, funding type, and pharmacy or stop loss carve in/out status.

Blue Shield will only submit data files for which Blue Shield provides all the coverage within the data file.

All entities reporting any information to the CMS must submit P2 Group Health Plan List data, along with any other required data elements.

In the case of groups with **pharmacy benefits carved in**, Blue Shield will submit D1 Premium and Life Years data for the first year reports are due (2022) as a good faith estimate, permitted by the regulatory agencies.

Groups with **pharmacy or stop loss carved out**, will be responsible for submitting D1 Premium and Life Years data, irrespective of the reporting year. Groups with pharmacy benefits carved out will also be responsible for submitting D3 – D8. Carve out carriers may submit data directly to the CMS in this case, however it is up to the group plan sponsor to discuss reporting responsibility with the carve out carrier.

Additionally, Blue Shield will be submitting D2-Spending-by-Category on an aggregate level for all group plan sponsors, regardless of pharmacy benefits or stop loss carve in or out status. When applicable, groups should review the CMS Reporting Guide to determine whether applicable data elements should be filed on an aggregate or client level.

Frequently Asked Questions

Reporting Deadlines

1. **When are reports due for CAA Sec 204 Pharmacy Drug Cost Reporting?**
   First reports, for reference years 2020 and 2021, are due on December 27, 2022. Following reports are due by June 1 of every year, including reports for year 2022 due June 1, 2023.

Reporting Responsibilities

2. **Where can I find details on reporting responsibility by LOB, funding type, pharmacy carve in/out status, and stop loss carve in/out status?**
   Please refer to the reporting responsibilities matrix for reporting responsibilities.

3. **For reports due in 2022, how is Blue Shield planning to report D1 Premium-and-Life-Years? What is the source of employee and employer contribution data?**
   We will be submitting estimated premium contribution data across a given LOB as the regulatory agencies are allowing a good faith effort for the first year. Since there are risks in doing so in the years to follow, we anticipate further guidance from the CMS on capturing and reporting D1 Premium and Life Year data. We will share more information as this becomes available.

4. **Can a pharmacy or stop loss carve out carrier submit reports on behalf of the group when applicable?**
   Carve out carriers may submit data directly to the CMS. It is up to the group plan sponsor to discuss reporting responsibility with the carve out carrier.

5. **Will Blue Shield file data for all plans under the main group number (i.e. for groups with multiple EINs)?**
   Yes, when it is Blue Shield responsibility to submit data elements, Blue Shield will file data for all plans under a given parent group.

6. **If an ASO group is a new customer as of 1/1/2022, do they have to submit reports due in 2022?**
   In this case, the group's first reports as a Blue Shield customer will be due June 1, 2023 for 2022 data. The previous carrier will be responsible for reports due in 2022 for coverage years 2020/2021, as applicable. Groups should check with their previous carrier for reporting responsibilities. Depending on group type, (please see the reporting responsibilities matrix for details) BSC will report 2022 data, as applicable to the group, by June 1, 2023.

7. **If a group plan sponsor was using another health insurance carrier in 2020, but using Blue Shield as the carrier in 2021, will Blue Shield still submit data for the year in which the group plan sponsor used Blue Shield as the carrier?**
   Blue Shield only submits data files where Blue Shield provides all coverage within the data file. The carrier providing coverage for 2020 will be responsible for 2020 reports due in 2022 as applicable. If Blue Shield was the carrier for 2021, then Blue Shield would be responsible for 2021 reports due in 2022 as applicable. Groups should check with their previous carrier for reporting responsibilities for any coverage years prior to becoming a Blue Shield customer.

File and Reporting Requirements

8. **Where and how should reports be submitted?**
   Groups responsible for submitting any data, should submit directly to the CMS. Groups should not submit data to Blue Shield to then submit to the CMS on their behalf. Blue Shield will be submitting data files for data elements for which Blue Shield provides coverage for. Please view page 8 in the CMS Reporting Guide for instructions on how to submit reports.

9. **What is the file format for the reports due?**
   Files should be submitted in a csv excel format. Please view page 59 in the CMS Reporting Guide for instructions on file format and requirements. Files must match the columns in the file templates, which can be found by scrolling down to RxDC templates (ZIP) under the resources section on the CMS website.

10. **What is a narrative response and what is the purpose of it?**
    A narrative response provides more detail on the data collection methodology. BSC's narrative responses are only pertinent to the

data files that BSC submits. Groups should submit their own narrative responses. Please view page 42 in the CMS Reporting Guide for guidance on developing a narrative response, including which topics and questions must be addressed.

Fees

11. **Will group plan sponsors be charged any fees for meeting compliance?**
    No, Blue Shield is not charging any fees for reporting data files for data elements for which Blue Shield provides coverage.

12. **Is Blue Shield offering a data collection campaign to allow groups to submit data to Blue Shield to submit to the CMS on behalf of the group for elements such as P2 Group-Health-Plan-List and D1 Premium-and-Life-Years for applicable groups?**
    No. Groups should not submit data to Blue Shield to then submit to the CMS on their behalf. Groups should submit any required data directly to the CMS. Blue Shield will be submitting data files for data elements for which Blue Shield provides coverage for as indicated in the reporting responsibilities matrix.

Other

13. **How do the requirements of CAA Sec 204 Pharmacy Drug Cost Reporting intersect with TCFR Machine Readable Files (MRF) pharmacy reporting?**
    Enforcement for displaying in-network negotiated prescription drug rates and allowed amounts as part of the Machine Readable Files (MRF) provision of the Transparency in Coverage Final Rule (TCFR) has been delayed until further rulemaking. Requirements of both TCFR MRF and CAA Sec 204 are intended to increase transparency among members, providers, and third parties to ultimately drive down the cost of prescription drugs from a consumer perspective.

Consolidated Appropriations Act: Provider Directories

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CAA: Provider Directories

H.R. 133, Division BB, Title 1, § 116

Background

The CAA issued standards for provider directory accuracy as a measure to protect enrollees from surprise billing.

Effective Date

January 1, 2022

Market Impacts

The requirements of this provision do not apply to jointly administered self-funded plans, or stand-alone dental, vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

1. *Plans must maintain an online provider directory for consumers that lists in-network providers and facilities, along with standard provider information.*
    - *Printed provider directories must:*
        - *state that directory information was accurate as of the date of publication,*
        - *state that the online directory has the most provider listings, and*
        - *identify state and federal contacts for members who believe there has been a violation.*
2. *Plans must verify directory information and remove nonresponsive providers or facilities at least every 90 days.*
3. *Plans are required to disclose balance billing protections online and on EOBs.*

Provider directory rules in California

In 2016, California's SB 137 defined more comprehensive requirements for provider directories than CAA now requires. Plans should ensure compliance with both CAA and SB 137.

California requires verification of provider directory data on the following schedule:

Requirement	Timing
update online provider directories	weekly
update paper provider directories	quarterly
validate most provider listings	annually
validate listings for individual practitioners, and dental and vision practitioners in specialty networks	every six months

Plans must define a period of time within which providers or facilities must be verified. Revisions provided by providers or facilities must be applied to the database within 2 business days.

Compliance

Health plans must maintain an accurate and up-to-date directory and database of in-network providers. The information must be available online, or in the case of a member inquiry, within one business day.

If an enrollee receives incorrect information from a plan about a provider's network status or relies on inaccurate provider directory, the patient will only be responsible for the in-network cost-sharing amount. The full amounts will count toward in-network deductibles and in-network out of pocket maximums.

Enforcement of most provider directory accuracy requirements is deferred until 2022, when regulations are expected. Use of the model disclosure notice issued in July 2021 will suffice for balance billing disclosures.[5]

Until regulations are issued, a plan will only be deemed noncompliant if it does not implement a process for adjusting out-of-network charges paid in reliance of provider directory information, including counting those cost-sharing amounts toward deductibles and out-of-pocket maximums.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Provider Directories provision?**

   The DOL intends to initiate rulemaking on these requirements sometime in 2022, the deadline for compliance is not extended. Compliance date is beginning on or after January 1, 2022.

   Once implemented, the final rules will have a prospective effective date.

   In 2016, California's SB 137 defined more comprehensive requirements for provider directories than CAA now requires. We ensure compliance with both CAA and SB 137.Blue Shield continues to ensure our provider directories are up to date and has contingency plans in compliance with the requirements ensuring in-network rates are charged when inaccurate provider network status information is obtained.

   Member and Provider EOBs must include No Surprise Billing language.

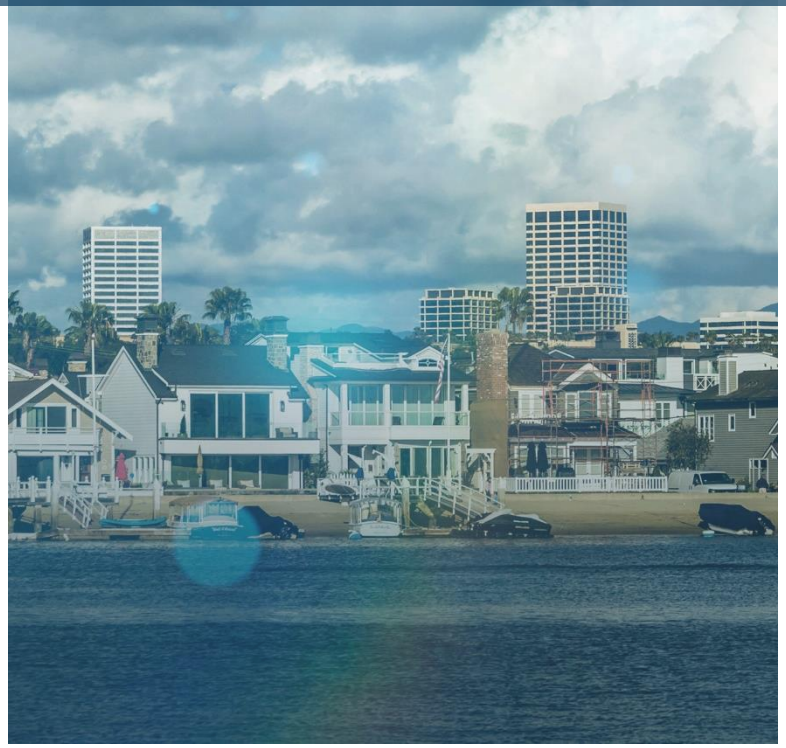
2. **Where can members find providers on Blue Shield's member facing website?**
   Members can search for a provider under Blue Shield's extensive provider network using the *Find a Doctor* tool.

3. **How is Blue Shield ensuring provider information is accurate?**
   Blue Shield has notified its network participants to inform them about how we are preparing to comply with the Provider Directory provision of the CAA. This outreach message also offered different methods providers can use to update their information for our members.

Additional FAQs are currently in development. Please check back for updates.

5 Requirements Related to Surprise Billing; Part I (July 1, 2021)

Consolidated Appropriations Act: Advanced EOB and Good Faith Estimate



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CAA: Advanced EOB and Good Faith Estimate

H.R. 133, Division BB, Title 1, § 111

Background

Providers will supply health plans a good faith estimate of their "expected charges" for an enrollee's scheduled services.

Effective Date

January 1, 2022, but enforcement is deferred until further regulatory guidance is issued

Market Impacts

The requirements of this provision do not apply to stand-alone dental, vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

Advance EOB Timing

Once the plan receives the provider estimate, it must send the Advance EOB to the enrollee within:

- *One business day, if the service is scheduled fewer than 10 days before the date the item or service will be furnished.*
- *Three business days, if the service is scheduled at least 10 days before the date the item or service will be furnished, or if requested by the enrollee.*

Plans may send the notification through mail or electronic means, as requested by the participant, beneficiary, or enrollee.

Content

Plans will use the provider estimate(s) in the format of an "Advance EOB" containing the information below.

1. *Whether the provider or facility are in-network*
2. *The contracted rate for the item or service if in-network, or*

3. *Information on finding in-network providers for the item or service if out-of-network.*
4. *The provider estimate, along with an estimate of the amount the health plan is responsible for paying, an estimate of the amount the enrollee is responsible for paying (cost-share) for the scheduled service, and an estimate of the amount the enrollee has incurred toward their deductible and cost-sharing limits.*
5. *If applicable, a disclaimer that medical management is required for the item or service.*
6. *A disclaimer that all information included in the Advance EOB is an estimate and subject to change.*
7. *Any other information or disclaimers that the health plan determines appropriate specific to Section 112.*

Compliance

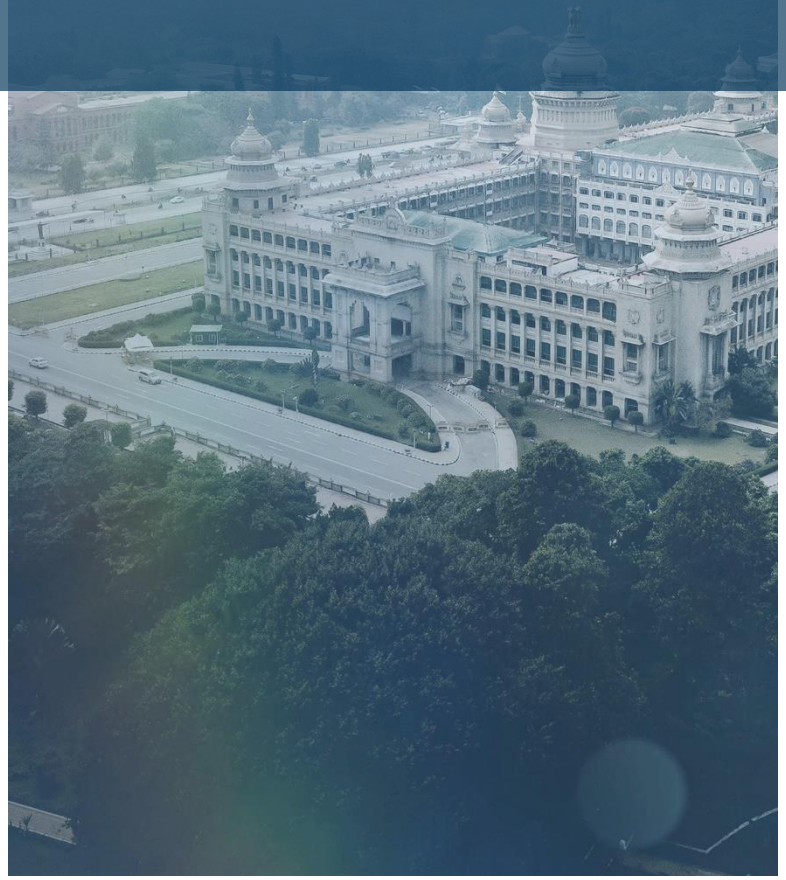
The Tri-Agency deferred enforcement indefinitely while regulators determine the feasibility of interim requirements. Plans encouraged to continue development, but the revised enforcement date will remain pending until regulations released.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Advance EOB and Good Faith Estimate provision?**
   The Tri-Agencies announced deferred enforcement of this requirement until further rulemaking due to a need for more information on the standards for data transfers between providers and health plans. Blue Shield project teams continue to work on all other unimpacted requirements and await further guidance.

Additional FAQs are currently in development. Please check back for updates.

Consolidated Appropriations Act: Insurance ID Cards



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CAA: Insurance ID Cards

H.R. 133, Division BB, Title 1, § 107

Background

CAA's Transparency Regarding Deductibles and Out-of-Pocket Limits amends participant ID requirements to improve cost transparency.

Effective Date

January 1, 2022

Market Impacts

The requirements of this provision do not apply to standalone dental, vision, or life insurance. For additional details, please see general market impacts for CAA.

Requirements

Physical or electronic ID cards must clearly display any in network and out-of-network deductible, and any out-of-pocket maximum limitations that apply to the participant's coverage.

ID cards must also display a telephone number and website address where consumers can seek further assistance, such as information related to hospitals and contracted urgent care facilities.

Compliance

Implementation will be enforced based on the plan's good faith, reasonable effort to comply.

Regulations are pending. They're expected to address layout challenges presented by complex plan designs with more extensive information requirements.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Insurance ID Card provision?**
   Blue Shield is on track to meet requirements. We will include required information on member ID cards and reissue ID cards to all members upon enrollment or renewal in a 2022 plan.

2. **What is the effective date to implement Section 107 for ID Cards?**
   Beginning on or after January 1, 2022, all plans for January 1, 2022 effective enrollments and any reenrollments thereafter would be issued a new ID card.

3. **Will Blue Shield print/digitize new ID cards for new enrollees?**
   Yes. Blue Shield will print/digitize new ID cards for new enrollees effective January 1, 2022 and after for compliance with CAA requirements.

4. **Will Blue Shield reprint/digitize new ID cards for all enrollees?**
   No. We will not retrigger/issue all new ID cards. New ID cards will be sent to members effective their renewal cycles January 1, 2022 and thereafter.

5. **Does Blue Shield have to re-issue a new ID card every time the deductible or out-of-pocket maximum changes?**
   Yes. Blue Shield is required to re-issue a new ID card every time the deductible or out-of-pocket maximum changes.

6. **Are medical and pharmacy deductibles required to be separate on the ID Card?**
   If medical and pharmacy have different deductibles, they need to be listed separately. If pharmacy is part of the medical deductible; it does not need to be listed.

7. **Can a member call customer service and request a new ID card starting January 1, 2022?**
   Yes. Beginning January 1, 2022, a member can call customer service and request a copy of the new ID card that reflects.

8. **Will Blue Shield digitize ID cards?**
   Yes. We will continue with our current path of printed and digital cards as established in existing requirements, for all lines of business.

9. **Will Blue Shield list a member's preferred language preference on their ID Card?**
   Yes. Blue Shield will list a member's preferred language preference on their ID Card.

10. **What lines of business are impacted by Section 107 of the CAA Transparency Regarding Deductibles and Out-of-Pocket Limits for ID Cards?**
    Individual, small group, and large group market, including self-insured plans and grandfathered plans.

11. **What lines of business are not impacted by Section 107 of the CAA Transparency Regarding Deductibles and Out-of-Pocket Limits for ID Cards?**
    Medicare Advantage, Medi-Cal, Cal Medi-Connect, Stand-Alone Dental or Vision, and Life

Member facing FAQs and ID Card templates can be found here.

Consolidated Appropriations Act: Price Comparison Tool

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CAA: Price Comparison Tool

H.R. 133, Division BB, Title 1, § 114

Background

Group health plans and health insurance issuers will maintain a "price comparison tool", which members can access online or by calling customer service. The tool will enable enrollees to compare cost-sharing for items and services furnished by participating providers.

Effective Date

January 1, 2022, but enforcement is deferred until further regulatory guidance is issued.

Market Impacts

The requirements of this provision do not apply to vision or dental plans embedded in medical plans; stand-alone dental, vision, or life insurance plans. For additional details, please see general market impacts for CAA.

Requirements

The price comparison tool must allow an enrollee to compare cost-sharing amounts for a specific item or service by a participating provider. Rates will be specific to the plan, plan year, geographic region, and participating provider.

Compliance

Enforcement of the price comparison tool will begin no earlier than 2023. The Tri-agency is currently evaluating CAA's price comparison tool requirements alongside TCFR's personalized cost sharing estimation tool with the goal of streamlining the requirements of both.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Price Comparison Tool?**

The requirements for CAA price comparison tool overlap with that of TCFR cost sharing estimator tool. The Tri-Agencies have acknowledged this and announced deferred enforcement until further rulemaking. Blue Shield continues to closely follow this and project teams have a plan to respond to further guidance and rulemaking.

Additional FAQs are currently in development. Please check back for updates.

Transparency in Coverage Final Rule: Personalized Cost Sharing Estimator

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TCFR: Personalized Cost Sharing Estimator

Effective Date

By January 1, 2023, the online cost share estimator must include the 500 most shoppable items and services.

By January 1, 2024, the online cost sharing estimator must include all procedures, drugs, durable medical equipment, and any other related items.

Market Impacts

For additional details, please see general market impacts for TCFR.

Requirements

Health plans and issuers must make available personalized out-of-pocket cost information for covered items and services, including information on negotiated rates. Information must be based on participants' actual plan and coverage.

A self-service online estimator tool must provide real-time results online and make results available on paper within 2 days after a request.

Required content reflects that of an explanation of benefits (EOB) supplied by plans after health care services are provided:

- Estimated cost-sharing liability,
- Accumulated amounts,
- Negotiated rates,
- Out-of-network allowed amounts,
- A list of items and services subject to bundled payment arrangements,
- A notice of prerequisites, if applicable, and
- A disclosure notice

Compliance

Regulators are evaluating the feasibility of issuing a single, streamlined set of requirements for TCRF's cost estimator tool and CAA's price comparison tool.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Personalized Cost Sharing Estimator Tool?**
   The requirements for CAA price comparison tool overlap with that of TCFR cost sharing estimator tool. The Tri-Agencies have acknowledged this and announced deferred enforcement until further rulemaking. Blue Shield continues to closely follow this and project teams have a plan to respond to further guidance and rulemaking.

Additional FAQs are currently in development. Please check back for updates.

Transparency in Coverage Final Rule: Publicly Available Machine Readable Files

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TCFR: Publicly Available Machine Readable Files

Background

The TCFR requires release of pricing files to support consumers' informed treatment decisions, and encourage price transparency innovations among researchers, employers, and developers.

Effective Date

January 1, 2022: initial effective date

July 1, 2022: Deferred enforcement date for files containing out-of-network allowed amounts and billed charges for covered items and services

Deferred enforcement date, pending development of regulations, for release of negotiated rates and historical net prices for covered prescription drugs

Market Impacts

For additional details, please see general market impacts for TCFR.

Requirements

Plans on the individual and group markets will publicly post three machine-readable files online:

1. in-network provider rates for covered items and services,
2. out-of-network allowed amounts and billed charges for covered items and services,
3. negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files (delayed enforcement)

Compliance

The files must:

- be updated on a monthly basis and clearly indicate the date when the files were last updated.
- associate specific pricing information with specific Provider IDs in all three files.
- conform to a non-proprietary, open-source standard format that is platform-independent.
- be made available to the public without restrictions that would impede re-use.

Frequently Asked Questions – General

1. **What does the July 1, 2022 deadline apply to?**
   The July 1, 2022 date applies for negotiated in-network provider rates; billed charges and out-of-network allowed amounts, in-network rates and out-of-network allowed amounts and billed charges for covered items and services.

2. **How does Blue Shield plan to meet the requirements of the Machine Readable Files (MRF) component of the TCFR?**
   Blue Shield is working in good faith to implement requirements of the Machine-Readable Files (MRF) provision for July 1, 2022.

   These files will be hosted by an external vendor and publicly available through a link on blueshieldca.com, or directly here: Blue Shield of California – Machine Readable Files

3. **What is required for fully-insured groups to meet MRF compliance?**
   Blue Shield of California will address the compliance obligation of the machine-readable file (MRF) provision of the Transparency in Coverage Final Rule (TCFR) as it applies to our fully-insured group plans.

4. **What is required of self-funded groups to meet MRF compliance?**
   Self-funded plan sponsors will need to post this same link from Blue Shield to their own websites for compliance purposes. It is up to the self-funded plan to determine where on its site to publish this link, but the link must be publicly available (no login or other requirements should be required to access the MRF files).

5. **Does this mandate impact service agreements with employer groups?**
   Blue Shield group service agreements for groups include our general obligation to comply with applicable law; no additional agreement or contract language changes are required for compliance with this mandate.

6. **How will other consumers and employers access the data?**
   Consistent with the requirements of the mandate, these MRF data is publicly accessible. Any of our clients, brokers, or third parties can access links to these files, as well as copy and post them to their own sites.

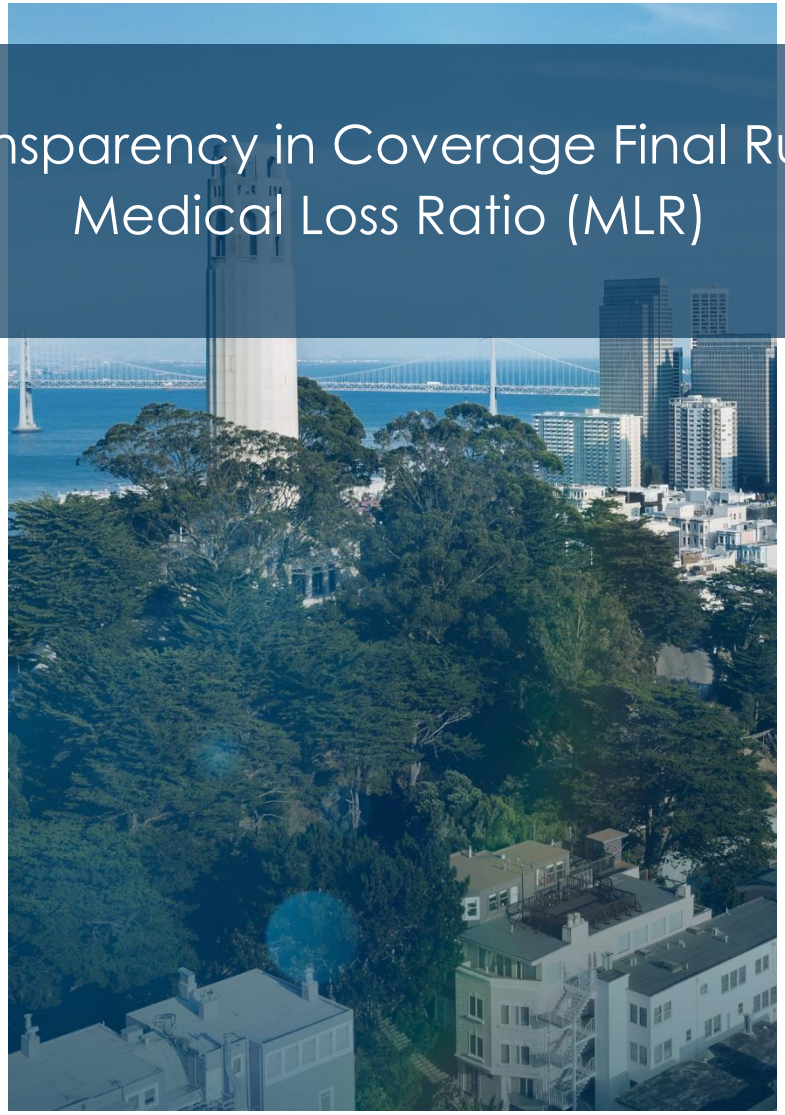
7. **Will the data be regularly updated and refreshed? If so, what is the expected frequency?**
   Yes, the data will be refreshed monthly. Data refresh dates will be clearly marked and visible to anyone accessing the MRF files.

8. **Will clients be charged a fee to access the MRF files?**
   There is no fee for clients to access, or copy, the MRF links on our website.

9. **What activities are ongoing with BCBSA and the Consortium around this mandate?**
   Blue Shield in conjunction with the Blue Cross Blue Shield Association, is in the process of implementing the requirements of this mandate.

Additional FAQs are currently in development. Please check back for updates.

Transparency in Coverage Final Rule: Medical Loss Ratio (MLR)



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TCFR: Medical Loss Ratio (MLR)

Background

The Affordable Care Act uses Medical Loss Ratio (MLR) to incentivize health plans to provide measurable value to participants. MLR determines what percentage of premiums are used to pay claims and enhance quality of care. Plans pay a rebate to consumers when their MLR is unfavorable to consumers. These plans are also subject to related tax consequences.

Effective Date

Beginning July 31, 2021 for 2020 MLR reporting year.

Market Impacts

For additional details, please see general market impacts for TCFR.

Requirements

TCRF revises the Medical Loss Ratio (MLR) calculation. The new methodology lets plans use "shared savings" payments in MLR calculations.

Shared savings are cost savings realized by consumers and plans as a result of plan designs that encourage consumers to choose lower-cost, higher value providers.

Calculation of shared savings amounts vary by plan design. Examples:

- A calculation of percent difference between the consumer's chosen provider's rate and the average negotiated rate for a procedure
- A flat dollar amount determined by different rate tiers defined by plans

Shared savings can be paid out to members as a gift card, cost sharing reduction, or premium credit.

Compliance

Shared savings are not

- treated as incurred claims or a quality improvement acts
- applicable when rebates owed when the benefit realized by consumers not currently captured in any existing MLR revenue or expense category

Regulations pending. However, guidance provided in the MLR Annual Reporting Form Instructions clarified how to report shared savings payments.

To date, HHS is expected to provide elements or criteria for "shared savings" program issuers.

Frequently Asked Questions – General

1. **How does Blue Shield plan to meet the requirements of the Medical Loss Ratio (MLR) component of the TCFR?**
   Standard MLR notifications have been sent out and we are evaluating the new methodology required by the provision.

Additional FAQs are currently in development. Please check back for updates.

Resources

Blue Shield Resources

- Broker connection mandates page
- Broker connection CAA & TCFR page

Government Resources

- DOL FAQs
- TCFR Fact Sheet