STAHL & ASSOCIATES INSURANCE

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THE CONSOLIDATED APPROPRIATIONS ACT (CAA) & THE TRANSPARENCY RULE

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BACKGROUND

The Consolidated Appropriations Act of 2021 (CAA) was signed into law on December 27, 2020 and is a comprehensive set of regulations that includes the No Surprises Act (NSA) and CAA transparency provisions. The No Surprises Act is aimed at protecting health plan members from surprise medical bills from out-of-network providers and facilitating dispute resolutions among providers and health plans. There are several additional provisions included in the NSA, including changes to health plan ID cards, advanced cost estimates and more. Transparency provisions require health insurers and group health plans to create a member-facing price comparison tool and post publicly available machine-readable files that include in and out-of-network charges for covered items and services.

For fully insured health plans, the insurance carrier is likely responsible for implementing several provisions within the CAA and the Transparency Rule. The chart below provides an overview of each provision along with a brief breakdown of the latest updates from several insurance carriers and how they are handling these changes for their fully insured business. If you are a self-funded client, we will be working with you specifically and your TPA to determine how to handle these updates.

CAA - NO SUPRISES ACT		
PROVISION	**DETAILS & KEY DATES**	**CARRIER RESPONSE**
Advanced Explanation of Benefits (EOB)	Advanced Explanation of Benefits must be provided by health plans at least three days in advance for scheduled services. The goal is to give patients transparency into which providers are expected to provide treatment, the providers' network status, and the expected cost. Providers are required to confirm coverage and send a notice to a patient's health plan of the estimated costs associated with the services scheduled three or more days in advance. Upon receipt of this information, health plans are required to send an Advance EOB to the member electronically or through mail. **Key Dates: Effective date: January 1, 2022.** **<u>Currently delayed until further rulemaking.</u>**	**Aetna:** Is awaiting final rulemaking in regard to advance EOBs. Aetna will continue to develop and enhance processes to ensure they follow these requirements. **Cigna:** As further rulemaking is provided, Cigna will share more information. **Florida Blue:** Awaiting further information. **Humana:** Is continuing to work toward this requirement as they await further information/rulemaking. **UnitedHealthcare:** Upon further rulemaking, UHC will handle advance cost estimates for the employer. If the group uses its own appeals vendor, the group will need to update.
Continuity of Care	Designed to keep patients from losing access to in-network providers and facilities during treatment, this requires health plans to offer continued care at an in-network rate for patients with complex care needs. Care must be	**Aetna:** Has a process in place that ensures member's claims will continue to be paid at the in-network level when the member requests continuity of care. **Cigna:** Has updated processes to meet the requirements of the law. New language will be updated in client policies and certificates upon renewal or as soon as possible thereafter.

	continued for up to a 90 day period if a provider changes network status due to: (1) The provider's contractual relationship is terminated; (2) the benefits are no longer provided because of a change in the terms of network participation; or (3) a contract between a group health plan and a health insurer is terminated, resulting in a loss of benefits provided under the plan with respect to such provider. The health plan must notify continuing care patients timely of the termination and their right to elect continued care. Members must also have a chance to notify the health plan for their need of continued care. **Key Dates: Effective January 1, 2022.** **<u>Until further regulations are issued, health plans are expected to comply using a reasonable, good faith interpretation of the law.</u>**	Fully insured/minimum premium clients will need to notify impacted employees of the opportunity to elect continuity of care when the client's insurance coverage ends with Cigna. **Florida Blue:** Florida Blue has implemented protections for enrollees to ensure continuity of care in instances where terminations of certain contractual relationships result in changes of provider and/or facility status. Florida Blue is reviewing their current continuity of care protocols to determine necessary changes and will work directly with impacted members on their transition of care. Florida Blue will update these protocols as further information is provided. **Humana:** Awaiting further information. **UnitedHealthcare:** Will notify all members who are impacted by a provider who is terminated from the network.
ID Cards	Health plans must include the following information, in clear	**Aetna:** Member cards contain a 1-800 number and website where members can access cost sharing information. Digital cards will be updated with the deductible and out-of-pocket maximum by the end of first quarter 2022.

	writing on any physical or electronic health plan ID cards: • In and out-of-network deductibles • In and out-of-network max out-of-pocket limitation • Phone number and website where a member can seek assistance in finding information on a network facility and provider **Key Dates: Effective January 1, 2022.** **<u>Until further regulations are issued, health plans are expected to comply using a reasonable, good faith interpretation of the law.</u>**	**Cigna:** Is making enhancements to ID cards to include the in-network and out-of-network deductibles and out-of-pocket maximums. • New Business - January 1, 2022 and after: ID cards will be mailed to customers with this new information and displayed on myCigna.com • Renewal Business - January 1, 2022 and after: updated ID cards will be printed and mailed at renewal only for a change of benefit, qualifying event election or individual member's request **Florida Blue:** Has updated member ID cards as of October 1, 2021, to comply with this provision. Florida Blue has added Virtual Visit PCP and Specialist copayment amounts to all ID cards. "Open Access Network" has also been added to BlueCare and Simply Blue HMO ID cards. **Humana:** Is updating ID cards to reflect deductibles or maximum out-of-pocket amounts for members. ID cards will also include the disclaimer; "Members: Amounts are not inclusive of all plan member cost sharing. Log into Humana.com or call Member/Provider Services for plan specifics." All new Humana medical business will be issued new compliant cards as of November 1, 2021. Existing customers who made benefits changes upon renewal will also receive new compliant cards. Any member requesting a new card after January 1, 2022, will receive the updated new compliant card. **UnitedHealthcare:** Is updating ID cards with the new information by plan effective date on or after January 1, 2022. Members can view and print their ID cards online or can call and request a card be mailed to them. Members will also receive communication explaining card changes and defining acronyms found on the card.
Provider Directories	Health plans must have up-to-date provider directories available to members online or within one business day of an inquiry. If a	**Aetna:** Has implemented several measures to validate the accuracy of provider directory information and will hold members harmless if they utilize inaccurate provider directory information.

	member provides documentation that information they received was incorrect prior to a visit, then the member will only be responsible for the in-network cost-sharing amount. Printed provider directories must include a notification that the directory was accurate on the date of publication and that the member should consult databases for most recent information. **Key Dates: Effective January 1, 2022.** **<u>Until further regulations are issued, health plans are expected to comply using a reasonable, good faith interpretation of the law.</u>**	**Cigna:** Provider digital contact information will be added, along with surprise billing disclosure to both directories and EOBs. Cigna is also evaluating the two-day turnaround requirement against their current process. Cigna has a process in place for handling customer calls about a provider's network status. Cigna has also created a letter to respond to customers within the 1-day turnaround time as requested in writing electronically or in print, per the customer's request. Member cost share liability will also be updated as required when notification of an incorrect directory network status is received. **Florida Blue:** Continues to apply existing process to verify network status of providers while awaiting further information. Member cost sharing will be limited to in-network amounts in instances where documentation shows that Florida Blue's directory was incorrect regarding provider's network status prior to the visit or service. **Humana:** Awaiting further information. **UnitedHealthcare:** Will update provider directories, verify provider data, and pay claims as in-network in certain instances when the directory is out of date. UnitedHealthcare is currently working on a process to update information using a two-day business turnaround time.
Surprise Medical Billing & Independent Dispute Resolution (IDR)	Sets standards to protect consumers from "surprise" or balance billing for defined items and services provided by specific doctors, hospitals, and air ambulance carriers on an out-of-network basis. This provision applies to the following:	**Aetna:** Will apply these consumer protections for fully insured plan sponsors as of January 1, 2022. For self-funded plans, consumer protections will align with the plan renewal date. Aetna self-funded clients that want to implement these protections prior to their renewal, must contact their Aetna Account Team or Stahl & Associates Account Executive. For IDR, Aetna is establishing a process for negotiation upon request from non-participating providers subject to the NSA after initial claim payment.

	- Out-of-network emergency services at hospital and freestanding facilities - Items and services provided by certain out-of-network health care providers at an in-network facility - Out-of-network air ambulance items/services "Surprise"/Balance billing may occur: - When notice and consent criteria is met - When a member chooses to go out-of-network - For ground ambulance Patients will only be responsible for in-network cost sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where they are unable to choose an in-network provider (including air ambulance providers). There must also be a process in place to settle health plan and provider disputes related to reimbursement for out-of-network emergency and certain out-of-network items/services provided at a network facility and air ambulance. When health plans and	**Cigna:** For no surprise claims, Cigna will calculate and apply the member's cost share at the in-network benefit level and reimburse providers as directed in the interim final rules. Cigna is also updating plan booklet language with the following changes: • Replaced ACA Emergency Services Language with No Surprises Act Language • Included Air Ambulance as a new category within the schedule • Revised schedule to make sure cost-share rules for NSA services align with NSA expectations Customer booklets will be updated upon renewal or as soon as possible thereafter. For Independent Dispute Resolution, Cigna will implement this process as directed by law. Cigna has also created a model notice to provide enrollees with information on their rights and protection against surprise medical bills. **Florida Blue:** Member cost sharing amounts for out-of-network emergency services (facility, physician, ambulance) will be updated to reflect the plan's in-network cost sharing amounts. Member cost sharing for non-emergency services performed by an out-of-network provider at qualifying in-network facilities will also reflect in-network amounts. Florida Blue will continue to evaluate existing processes for handling payment disputes to determine updates needed for IDR process. Florida Blue has also created a model notice to provide enrollees with information on their rights and protection against surprise medical bills which can be found at **https://www.floridablue.com/binaries/content/assets/floridablue/en/forms-and-documents/member/no-surprises-act-model-notice-012022.pdf** **Humana:** Awaiting further information. **UnitedHealthcare:** Will provide end to end support for this process for negotiating surprise medical bills with providers and administering the IDR

	providers cannot reach an agreement, an Independent Dispute Resolution (IDR) process is established to determine the final reimbursement. The IDR process sets timetables and holds the consumer harmless. The entity that "loses", pays the IDR expenses to the other party. **Key Dates: Effective January 1, 2022.**	process for health plans. EOBs will be updated with balance bill and cost share language. UnitedHealthcare will handle intake of dispute and determination if eligible for IDR based on applicable law. Additionally, they will engage the provider in the formal negotiation process in accordance with required timelines. If agreement is not made and provider invokes formal arbitration within the required timeline, then UnitedHealthcare will administer the formal process. UnitedHealthcare is also preparing disclosures that are required under the NSA and will post a notice to uhc.com.
CAA – TRANSPARENCY		
PROVISION	**DETAILS & KEY DATES**	**CARRIER RESPONSE**
Gag Clauses	Bans gag clauses in contracts between providers and health plans that would prevent enrollees, plan sponsors, or referring providers from seeing provider-specific cost and quality data. **Key Dates: Already effective as of December 27, 2020**	**Aetna:** Current contracts are compliant – no action needed. **Cigna:** Does not standardly enter any contract that would prohibit the disclosure of information outlined in the CAA. Cigna continues to review nonstandard contracts and if such language is identified, it will be removed from the contract as soon as practicable. **Florida Blue:** Is sending notices to providers with gag clauses currently in their contacts to inform them of the new regulations. **Humana:** Awaiting further information. **UnitedHealthcare:** Will maintain network agreement compliance with the CAA prohibitions on gag clauses and provide language to support plan sponsor's attestation requirement. Attestation confirming compliance must be submitted annually by the insurer or health plan. UnitedHealthcare has also prepared a statement for self-funded clients to include in their attestation.

Broker Compensation Disclosure	Health benefit brokers and consultants are required to disclose to plan sponsors in the group market any direct or indirect compensation the brokers and consultants receive. **Key Dates: Effective December 27, 2021.**	**Aetna:** Awaiting further information. **Cigna:** Provides certain broker compensation information to both brokers and clients. Information can be found on the ERISA form 5500, 1099 form and through Cigna's Paid Compensation statements. **Florida Blue:** Awaiting further information/rulemaking and will provide more information as it becomes available. **Humana:** Awaiting further information. **UnitedHealthcare:** Will provide brokers and third parties with information regarding where they may access any compensation information to put in their disclosure to the customer. The customer fiduciary should then review this information.
Reporting Pharmacy Benefits & RX costs	Requires health plans to annually report information on prescription drug benefits and medical costs to the Secretaries of HHS, Labor and the Treasury. **Key Dates: Effective December 27, 2022 (for plan years 2020 and 2021 and by June 1st annually thereafter.)** **Further rulemaking expected in 2022.**	**Aetna:** While awaiting further rulemaking, Aetna will continue discussions related to those specific data elements. **Cigna:** Is assessing the requirements to form an approach that meets compliance dates. Additional information to follow after further rulemaking is determined. **Florida Blue:** Awaiting further information. **Humana:** Awaiting further information. **UnitedHealthcare:** Is continuing to determine how to collect and report this information as further rulemaking is developed.
Mental Health Parity	Requires that plans perform and provide to a regulator or participant	**Aetna:** Maintains a NQTL comparability analysis document that they use to respond to regulators regarding fully insured plans. Aetna can provide this to

	upon request, a comparative analysis for any non-quantitative treatment limitation (NQTL) applied to mental health/substance use disorder (MH/SUD) benefits. **Key Dates: Already effective as of February 10, 2021**	self-funded clients upon request. Self-funded clients are responsible for determining compliance. Aetna does not complete NQTL testing for self-funded plans as compliance is responsibility of the self-funded customer and member cost share is an element of plan design controlled by a self-funded plan. **Cigna:** If a client should receive a notice from the DOL audit requesting NQTL comparative analysis, they should contact Cigna immediately and provide a copy of the letter. Cigna will assist in providing documentation that is responsible to the issues within the letter. **Florida Blue:** Requests from state or federal agencies regarding mental health parity analysis should be sent to Florida Blue to determine the appropriate response and/or support needed. Florida Blue will conduct the mental health parity analysis and respond to inquiries from state or federal agencies for fully insured groups. Self-insured clients are responsible for demonstrating compliance with mental health parity requirements. Florida Blue will work with their self-insured groups to provide information that assists them in developing a response. **Humana:** Awaiting further information. **UnitedHealthcare:** Will provide documentation to appropriate regulators upon request for fully insured plans. For self-funded plans UnitedHealthcare will provide standard documentation for them to analyze and prepare the report is asked. If a self-funded client is requested to send their analysis and report by the federal agency, UHC will work with the customers to review their analysis/report, gather information, and help them finalize their audit response.

TRANSPARENCY IN COVERAGE RULE		
PROVISION	**DETAILS & KEY DATES**	**CARRIER RESPONSE**
Machine-Readable Files (MRF)	Requires health plans to create and post detailed pricing data via three separate machine-readable files including: 1. In-network negotiated rates for all items and services 2. Allowed amounts for out-of-network items, services and prescription drugs 3. Negotiated rates for historical prices for in-network prescription drugs. **Key Dates: Effective July 1, 2022.** **<u>Further rulemaking expected in regard to prescription drug files.</u>**	**Aetna:** For fully insured and self-funded groups under 100 lives, Aetna will post the required data. For all other self-funded clients, Aetna will provide the URL (link) to the required data to which plan sponsors can post to their public-facing website. **Cigna:** Will host MRFs on clients' behalf on cigna.com. This will include in-network medical and out-of-network medical MRFs for clients and will also include behavioral. This will be the standard offering. Clients will need to add a link to their own public website back to Cigna.com. A public-facing website is not an internal intranet site and cannot have a sign in required. On May 16, 2022, Cigna clients will receive communications that provide the link to the MRFs and the actions needed to be compliant. For clients who previously indicated they do not have a public website or clients with client-specific networks, Cigna will communicate the URL of the websites they have created for clients. For clients who "opted out" of Cigna's standard hosting services by choosing to host their own files or having a third party host the files, Cigna will be supplying detailed instructions for how to access the files from Cignaforemployers.com On or before July 1, 2022, clients will need to post the following link to their public website to provide access to the MRFs. The link is https://www.cigna.com/legal/compliance/machine-readable-files. Prior to July 1, 2022, the link will take visitors to the Cigna.com home page. After July 1, 2022 this link will bring pull up the MRFs page. Cigna has also provided specific language to clients that they recommend be posted along with the link. Cigna will update the files each month and the link will remain constant so clients will only need to follow this process once to establish the link.

		Florida Blue: Is continuing to develop in and out-of-network files, related procedures for updating and posting the files, and how they will assist fully insured and self-insured clients with compliance efforts. More information to follow as further information is released. **Humana:** Will include all custom fee schedules within their MRF publication. Humana will publish these files on their publicly available website. ASO groups will need to add a link to their own public website back to the Humana site/link that hosts these machine-readable files. **UnitedHealthcare:** Will create and publish files on a publicly accessible website for clients including those who are self-funded. These files will be available on a publicly available website beginning July 1, 2022 and updated monthly. MRFs will be posted on transparency-in-coverage.uhc.com. and groups will need to post the link to files on their publicly accessible website.
Cost Comparison/ Transparency Tool	The CAA requires health plans to have a price comparison tool available for consumers. This information must be available via website and by phone. This tool should allow an enrollee/potential member to compare the amount of cost sharing they would be responsible for under their plan for a specific item or service by providers. The Transparency in Coverage Rule also requires health plans to permit participants to compare costs of services from in-network providers and is far more detailed than the CAA provisions. The effective dates are also	**Aetna:** Is building the Cost Estimator Tool for all medical customers to be available on January 1, 2023, and then enhanced January 1, 2024. **Cigna:** Is actively working to expand their existing cost estimator tools to comply with Transparency in Coverage requirements, effective 2023 and 2024. More information to follow, as further rulemaking is provided. **Florida Blue:** Awaiting further information. In the interim, Florida Blue's existing cost estimate and price comparison tools are available to all members to help with their evaluation of out-of-pocket costs for covered services. **Humana:** By January 2023, Humana will make available real time out-of-pocket cost estimates for covered items and services available to members through a searchable internet tool.

	different. Under TIC rules, health plans must be able to provide cost sharing information to members for a set of 500 specific items by January 1, 2023, and then all items by January 1, 2024. The Departments are considering whether the TIC will satisfy the requirements of the CAA. **Key Dates: Effective January 1, 2022.** **<u>Enforcement has been delayed until January 1, 2023, to align with the Transparency in Coverage (TIC) rule.</u>**	**UnitedHealthcare:** Will build off current tools available to members and health care providers about the cost and quality of care to comply with requirements by 2023 and 2024. Current tools include, myuhc.com, UnitedHealthcare app, Rally Connect, Point of Care Assist and MyScriptFinder.

NEXT STEPS

The Consolidated Appropriations Act and Transparency in Coverage Rule are both complex and have broad impacts across the health care industry for insurers, providers, brokers, and patients. Until further guidance is received, the full extent of changes being made by health insurers, and the full impact of these changes is unknown.

Stahl & Associates Insurance is closely monitoring the CAA and TIC rules, and we will continue to keep you updated as developments arise. Should you have any questions, please contact your Account Executive at Stahl & Associates Insurance for additional information. We are happy to assist you.

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