Transparency in Coverage Final Rule Consolidated Appropriations Act

2021 Update (9.2021)

HCIactive The Advanced Health Planning Company

90 DEGREE BENEFITS
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Transparency in Coverage (TiC) Final Rule and Consolidated Appropriations Act (CAA)

The Consolidated Appropriations Act, 2021, enacted on December 27, 2020 as Public Law 116-20, includes roughly $900 billion in COVID-19 relief as well as many provisions to address surprise medical billing and pricing transparency through the No Surprises Act. Separately, the Department of Health and Human Services (HHS), the Department of Labor and the Department of the Treasury (the Departments) released the Transparency in Coverage final rule to deliver on Executive Order 13877. The final rule's requirements also address pricing transparency.

We at 90 Degree Benefits, your Third-Party Administrator, are working diligently to address the requirements of the Transparency in Coverage Final Rules and the Consolidated Appropriations Act, and we are confident we will have everything in place by the enforcement dates. Please reach out to compliance@90degreebenefits.com with any specific questions you may have.

Below is a high-level, overall summary of the requirements from the Transparency in Coverage Final Rules and the Consolidated Appropriations Act.

Transparency in Coverage Machine-Readable Files

Requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered coverage in the group and individual markets to disclose on a public website information regarding in-network provider rates for covered items and services, out-of-network allowed amounts and billed charges for covered items and services, and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. The machine-readable file requirements of the TiC Final Rules are applicable for plan years (in the individual market, policy years) beginning on or after January 1, 2022.

CMS Update – August 20, 2021 | The Departments will enforce machine-readable file provisions in the TiC Final Rules, subject to two exceptions:

1. The Departments will defer enforcement of the TiC Final Rules' requirement that plans and issuers publish machine-readable files relating to prescription drug pricing pending any further rulemaking.
2. The Departments will defer enforcement of the TiC Final Rules' requirements to publish the remaining machine-readable files (in-network rates and out-of-network allowed amounts and billed charges) until July 1, 2022.

90 Degree Benefits Update | It is expected that the networks and PBMs will produce the machine-readable files. If the networks are unable to produce these files, our portal vendor, HCIactive will assist with creating files in a compliant format after the networks provide the necessary data.

Price Comparison Tools

Requires plans and issuers to make price comparison information available to participants, beneficiaries, and enrollees through an internet-based self-service tool and in paper form, upon request. This information must be available for plan years (in the individual market, policy years), beginning on or after January 1, 2023, with respect to the 500 items and services identified by the Departments, and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.

The CAA requires plans and issuers to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that (to the extent practical) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of specific item or service by any such provider.

CMS Update – August 20 | Because the price comparison methods required by the CAA are largely duplicative of the internet-based self-service tool component of the TiC Final Rules, the Departments intend to:

- Propose rulemaking and seek public comment regarding, among other issues, whether compliance with the internet-based self-service tool requirements of the TiC Final Rules satisfies the analogous requirements set forth in the CAA.
- Propose rulemaking requiring that the same pricing information that is available through the online tool or in paper form, as described in the TiC Final Rules, must also be provided over the telephone upon request.

The Departments will defer enforcement of the requirement that a plan or issuer make available a price comparison tool (by internet website, in paper form, or telephone) for plan years (in the individual market, policy years), beginning on or after January 1, 2023, aligning the enforcement date of the CAA requirements with the TiC Final Rules requirements.

90 Degree Benefits Update | HCIactive is designing a pricing tool to be accessed via the member portal. The tool will allow covered members to compare cost-sharing for items and services rendered by a participating provider. This data must be provided to HCIactive by the networks.

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No Surprises Act (NSA)

Requires health plans to cover emergency services at a non-participating facility, services/items provided by non-participating providers at a participating facility, or non-participating provider air ambulance services with the same participating cost-sharing whether the services are from a participating or non-participating provider or facility. The Act protects patients who receive these services from being balance billed by the non-participating provider and makes them only responsible for paying their in-network cost sharing in most circumstances. The No Surprises Act also requires the health plan to use a Qualifying Payment Amount in certain situations, and it establishes a new Independent Dispute Resolution process for health plans and providers. Health plans will also be required to allow an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a plan.

Advance Cost Estimates and Explanation of Benefits (EOB)

Requires plans and issuers, upon receiving a "good faith estimate" regarding an item or service, to send a participant, beneficiary, or enrollee (through mail or electronic means, as requested), an Advanced Explanation of Benefits notification in clear and understandable language. The notification must include:

1. The network status of the provider or facility;
2. The contracted rate for the item or service, or if the provider of facility is not a participating provider or facility, a description of how the individual can obtain information on the providers and facilities that are participating;
3. The good faith estimate received from the provider;
4. A good faith estimate of the amount the plan or coverage is responsible for paying, and the amount of any cost-sharing for which the individual would be responsible for paying;
5. Disclaimers indicating whether coverage is subject to any medical management techniques; and
6. Relevant disclaimers of estimates.

These provisions apply with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

CMS Update – August 20 | The Departments agree that compliance with this section is not likely possible by January 1, 2022, and therefore intend to undertake notice and comment rulemaking in the future to implement this provision, including establishing appropriate data transfer standards. Until that time, the Departments will defer enforcement of the requirement that plans and issuers must provide an Advanced Explanation of Benefits.

90 Degree Benefits Update | HCIactive is developing a workflow to capture Advanced EOB requests from members via the member portal and providers via the provider portal. The collected information will be submitted to our clients' EOB vendors for Advanced EOB paper delivery fulfillment. If appropriate and feasible, HCIactive may be able to integrate directly with your EOB and fulfillment vendor. Electronic Advanced EOB fulfillment can occur through the member portal if an existing integration exists.

Transparency in Plan or Insurance ID Cards

Requires plans and issuers to include, in clear writing, on any physical or electronic ID card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance. These provisions apply with respect to plan years (in the individual market policy years) beginning on or after January 1, 2022.

CMS Update – August 20 | Pending future rulemaking, plans and issuers are expected to implement the ID card requirements using a good faith, reasonable interpretation of the statute.

Continuity of Care

For individuals who are undergoing treatment for a "serious and complex condition," pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill, requires a group health plan to provide 90 days of continued, in-network care if 1) a provider or facility voluntarily leaves the network, 2) benefits are terminated because of a change in the terms of the participation of the provider or facility, or 3) the contract between plan and issuer is terminated resulting in loss of benefits. Also requires the group health plan to notify individuals receiving care of the network change and provide the option to continue care for the transitional period. These provisions are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

CMS Update – August 20 | Until rulemaking to fully implement the provisions is adopted and applicable, plans, issuers, providers, and facilities are expected to implement the requirements using a good faith, reasonable interpretation of the statute.

Mental Health Parity

Health plans must perform and document comparative analyses of the design and application of non-quantitative treatment limitations (NQTLs) and make them available upon request to the secretary of the DOL or HHS as applicable.

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Prohibition on Gag Clauses and Quality Data

Prohibits plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from:

1. Providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;
2. Electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and
3. Sharing such information, consistent with applicable privacy regulations.

These provisions are effective December 27, 2020.

CMS Update – August 20 | Until any further guidance is issued, plans and issuers are expected to implement the requirements prohibiting gag clauses using a good faith, reasonable interpretation of the statute.

Broker and Consultant Compensation

Amends ERISA Section 408(b)(2) to require disclosure of any direct or indirect compensation for brokerage services or consulting – terms that are defined very broadly.

Pharmacy Drug Cost Reporting

Requires health plans to report annual data to HHS, the DOL, and the Department of Treasury on drug utilization, spending and rebates.

CMS Update – August 20 | The Departments will defer enforcement of the requirement to report the specified information by the first deadline for reporting on December 27, 2021 or the second deadline for reporting on June 1, 2022, pending the issuance of regulations or further guidance.

Protecting Patients and Improving the Accuracy of Provider Directory Information

Establishes standards related to provider directories that are intended to protect participants, beneficiaries, and enrollees with benefits under a plan or coverage from surprise billing. These provisions generally require plans and issuers to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee, about a provider's network status. These provisions are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

CMS Update – August 20 | Until further guidance or rulemaking is issued, plans and issuers are expected to implement these requirements using a good faith, reasonable interpretation of the statute.

90 Degree Benefits Update | Where feasible, HCIactive will produce a public provider search tool, or link to health plans' provider directories as appropriate. Some health plan providers are creating their own directories which the HCIactive portals can link to.