Transparency in Coverage Rule
Consolidated Appropriations Act
Information for Employers

December 14, 2021

What employers need to know about our compliance with the Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TiC) – and steps employers need to take.

Transparency in Coverage Rule

TiC requires non-grandfathered group health plans and insurance issuers to publish certain healthcare price estimates – both via publicly available website, and personalized cost-sharing information to plan members.

Machine-Readable Files

Insurers/plans must create and publicly post machine-readable files (MRF) with detailed in-network and out-of-network pricing data.

Compliance Status: We will post BlueCard pricing MRF to our public website. These will be general, not employer specific links. For custom pricing, we will generate the MRF and post to an employer-specific non-secure microsite. Out-of-network MRFs will also be posted to our public website. Files will be available for download without login by the July 1, 2022 enforcement date.

Employer Actions Required: None at this time.

Price Transparency Tool

Insurers/plans must provide a price transparency tool for use by members with personalized, real-time estimates of cost of care. By January 1, 2023, the tool must include information for 500 items and services; by January 1, 2024, it must include all covered items and services.

Compliance Status: We are already largely compliant via our Shopping for Care tool and will continue to add pricing data to comply with expanded requirements for January 2023 and January 2024.

Employer Actions Required: Action only needed if an employer had previously requested to turn off our Shopping for Care tool for their employees. We will work with these employers to determine the best course of action for achieving compliance. Please note that our tool supports carved-in benefits only.

Consolidated Appropriations Act

CAA provides protections for patients from surprise medical bills and a number of other health-related provisions.

Advance Cost Estimates and Explanation of Benefits

Upon being provided a good faith estimate by a provider/facility, group health plans must provide an advance EOB for scheduled services in three days (or if the scheduled service is less than 10 days away, in one business day) to give patients transparency into: which providers are expected to provide treatment and their network status; good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums; and if a service is subject to medical management and relevant disclaimers of estimates.

Compliance Status: This provision is on hold pending further guidance.

Employer Actions Required: None

Broker and Consultant Compensation Disclosure

Requires covered service providers who provide brokerage and consulting services to disclose to group health plan sponsors any direct or indirect compensation received for brokerage or consulting services.

Compliance Status: We have updated processes to meet the requirements of this section.

Employer Actions Required: None

Continuity of Care

Requires a group health plan or health insurance issuer to provide 90 days of continued, in-network care for continuing care patients if a provider or facility leaves the network. Continuing care patients generally are individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill.

Compliance Status: We are leveraging existing processes to meet the requirements of this section.

Employer Actions Required: None

Flexible Spending Accounts

Implemented several temporary changes for FSAs related to carryover, grace period and election changes.

Compliance Status: We are already compliant via changes made to systems and processes.

Employer Actions Required: None

Gag Clauses

This provision prohibits gag clauses on sharing cost and quality information in payer-provider contracting.

Compliance Status: We are compliant with this provision. We have updated group and provider contracts in accordance with the regulations.

Employer Actions Required: None

Consolidated Appropriations Act

Insurance ID Cards

Requires group and individual health plans to identify the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and Internet website address through which individuals may seek consumer assistance information, on insurance cards.

Compliance Status: We will be compliant by the effective date of the provision (January 1, 2022). Updated digital cards will be available for all members on My Health Toolkit® or by contacting Customer Service. Members who will receive a new hard copy ID card — for example, after changes that require a new alpha prefix for the member ID or the addition of pharmacy coverage — will receive a card which will contain the required information.

Employer Actions Required: None

Mental Health Parity

Requires group/individual health plans and Medicaid managed care organizations to perform, document and to provide upon request comparative analyses of the design and application of non-quantitative treatment limitations (NQTL).

Compliance Status: Self-funded group health plan sponsors are responsible for ensuring plans are compliant with the Mental Health Parity and Addiction Equity Act ("MHPAEA"). We will provide discrete information to assist the employer in performing the required analysis. However, we do not perform any MHPAEA testing for our self-funded groups, nor do we make any representations or warranties as to any self-funded plan design's compliance with MHPAEA.

Employer Actions Required: Plan sponsors should discuss compliance with their legal counsel.

Pharmacy Benefits and Drug Costs Reporting

Requires group and individual health plans to report annual data to HHS, the Department of Labor, and the Department of Treasury (Tri-agencies) on drug utilization, spending and rebates, as well as total spending on health care services by type (e.g. hospital, primary care, prescription drugs, etc.). Interim Final Rules allow the first two reports covering calendar years 2020 and 2021 originally due December 27, 2021, and June 1, 2022, respectfully, to be submitted prior to December 27, 2022. For calendar years beginning on and after 2022, the annual report will be due every June 1. For instance, data for calendar year 2022 is due June 1, 2023.

Compliance Status: We are positioned to meet reporting deadlines.

Employer Actions Required: None

Consolidated Appropriations Act

Price Comparison Tools

Requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.

Compliance Status: We have an existing tool in place to satisfy CAA requirements for most benefit plans.

Employer Actions Required: Action only needed if an employer had previously requested to turn off our Shopping for Care tool for their employees. We will work with these employers to determine the best course of action for achieving compliance. Please note that our tool supports carved-in benefits only.

Prior Authorization of OB/GYN Services

Group health plans and health insurance issuers continue to be prohibited from requiring prior authorization for obstetrical and gynecological care, including the ordering of related OB/GYN items and services.

Compliance Status: We are already compliant, as we do not require prior authorization for obstetrical or gynecological care.

Employer Actions Required: None

Provider Directories

Health plans must establish a public-facing provider directory that contains certain information and establish a verification process to confirm the accuracy of provider directory information at least every 90 days.

If a member provides documentation that they received incorrect information about a provider's network status prior to a visit, the patient is only responsible for the in-network cost-sharing amount and the visit will apply to the member's deductible or out-of-pocket maximum, if applicable.

For plan years starting on January 1, 2022, or later, plans must include on their public websites and on each explanation of benefits, a disclosure of the balance billing prohibitions included in the CAA and information on state and federal contacts if the member believes there has been a violation.

Compliance Status: We are updating our systems to meet the requirements by the applicable effective date.

Employer Actions Required: None

Consolidated Appropriations Act

Surprise Billing

Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations (including air ambulance providers).

Prohibits providers from balance billing except in limited circumstances with patient notice and consent.

Provides access to an independent dispute resolution (IDR) process for providers and plans who cannot reach an agreement on payment.

Compliance Status: Surprise Billing requirements will be in place by the applicable effective date for renewals after January 1, 2022 and after. We will process claims subject to the No Surprises Act as in-network regardless of provider network status, and make provider payments, within the required timeliness standards. We will utilize an indicator on the claim that indicates a member has given consent for balance billing and will review the consent form prior to processing the claim. At this time, we do expect to handle the IDR process in-house, and will comply with final rules regarding the IDR provision.

Employer Actions Required: Our standard process will implement Surprise Billing rules for all groups as of January 1, 2022. If groups have questions about the timing of this implementation, they should discuss with their National Alliance Marketing Consultant.

Additional information about surprise billing available here.

CAA and TiC Timeline

Based on August 20, 2021 Guidance

Before 12/31/2021

- FSA provisions (beginning with 2020 plan years)
- Gag Clause rules 12/27/2020
- Mental Health Parity 2/10/21
- Broker and Consultant Compensation Disclosure 12/27/21

1/1/2022

- ID card requirements
- Provider Directory requirements
- Balance billing publication and disclosure requirements (via public website and EOBs)
- Continuity of Care requirements
- Prior Authorization of OB/GYN services

7/1/2022

- Machine-readable files for INN/OON (not Rx)

Applies to plan years starting 1/1/22-7/1/22; for 2022 plan years starting after that, files required first month of plan year

1/1/2023

- Price Comparison Tool – 500 items and services

1/1/2024

- Price Comparison Tool – all covered items and services