EMPLOYER BULLETIN

Consolidated Appropriations Act (CAA) and Transparency in Coverage Update

January 2024

BlueCross BlueShield Minnesota

The Consolidated Appropriations Act (CAA), 2021 is referred to as "the most comprehensive single piece of legislation to impact group health plans since the Affordable Care Act (ACA)". There was limited ability to comment and shape this legislation ahead of time and little commentary about meaning/policy goals behind the statutory language. In addition to the CAA legislation, many areas overlap with work also required in the Transparency in Coverage Act.
BCBSM, Inc. d/b/a Blue Cross and Blue Shield of Minnesota ("Blue Cross")
is working on these pieces of legislation together.

- Blue Cross continues to monitor and respond appropriately when new rules or additional guidance is issued.
- As with all federal and state rulings, Blue Cross is committed to complying with these and all new requirements by their applicable dates.
- We also recognize that adjustments and iterations may be necessary once the final rules are published.

Blue Cross continues to support the CAA and Transparency in Coverage Act. The program has business owners and many functional resources across the organization, driving efficiency to meet timelines.

Please note: No Surprises Act Sections 102, 103, 104, 105, 107, 116 and Transparency Sections 201, 202 and 203 have been moved to the Appendix section at the end of the document. These Sections have been implemented and require no further action.

Transparency - Gag Clause Annual Attestation requirement

Under the Consolidated Appropriations Act, 2021 ("CAA 2021"), group health plans and insurers are prohibited from having "gag clauses" in their contracts with healthcare providers and other third parties. To uphold this provision, group health plans are required to submit an annual attestation of compliance to CMS beginning December 31, 2023.

The Department of Labor (DOL), Health and Human Services (HHS), and Treasury (the Departments) have outlined the process group health plans and insurers must follow for submitting the annual attestation. This guidance is available in ACA and CAA 2021 FAQs Part 57, released on February 24, 2023.

We want to assure you that our provider contracts (for the purposes of attestation) have been reviewed and we have confirmed they contain no gag clauses. Furthermore, Prime Therapeutics' contracts with network pharmacies are also free from such clauses.

Blue Cross will manage the attestations required for fully insured clients. There is no action needed for fully insured clients with Blue Cross.

For self-insured clients, it is important to note that you are responsible for your own attestation process. To assist you, we have provided links below that offer guidance and support for the process.

Most of the data needed for these attestations is information that you already possess, including:

- Name of the entity
- Employer Identification Number (EIN)
- Plan number
- Type of entity (medical, pharmacy, behavioral health, etc.)
- Mailing address
- Contact name
- Email address
- Phone number

For self-insured clients, it is imperative to attest on your own behalf, using the provided links and resources. Compliance

attestation instructions, along with a user manual for submitting the Gag Clause Prohibition Compliance Attestation (GCPCA), can be accessed on the CMS website.
Gag Clause Prohibition Compliance Attestation | CMS

Gag Clause Resources:
Frequently Asked Questions
Instructions for submitting the GCPCA
User Manual for submitting the GCPCA
Enter Webform Now for a GCPCA

Consolidated Appropriations Act:
The two sections of the CAA that have significant health plan provisions impacting Commercial Markets are the No Surprises Act and Transparency in Coverage.

No Surprises: Reporting requirements regarding air ambulance services **(Section 106)**
This section creates new reporting requirements for providers and plans related to air ambulance services. For plans, certain claims data related to air ambulance services must be reported. This data includes, for example, information on the provider, originating location of services (rural or urban), and whether the service was an emergency.

Upcoming final rules will specify the final reporting requirements, including the data elements and the deadlines for the data collection. The data collection will not begin until after the final rules are published. Blue Cross is waiting for additional guidance on the next steps.

No Surprises: Advanced Explanation of Benefits (AEOB) (Section 111)
All patients have the ability to request an Advanced EOB that gives an estimated cost of the reasonably expected services that will occur with that visit.

There are many requirements for the AEOB, including:
- The network status of facility or provider
- If in-network, the contracted rate for the service based on relevant billing and diagnostic codes
- If out-of-network, a description of where to find information on in-network providers and facilities
- An estimate of the amount the plan will pay
- An estimate of the participant's cost sharing responsibility for the services as of the date of the notice
- An estimate of amount the participant has incurred toward their cost sharing limits, including deductible and out-of-pocket maximums, as of the date of the notice

Blue Cross continues to work with our business partners to understand the scope of work needed and eagerly awaits further rulemaking before moving forward with finalized development. To date, there has been no further guidance provided.

Blue Cross will have a systematic solution in place for providers to submit a request for an advanced explanation of benefit notification. In addition, we will use our current provider communication channels to educate and communicate AEOB details as they become available. Blue Cross will generate and send AEOBs. They will also be available on the member portal.

No Surprises: Continuity of Care (Section 113)
Requires fully insured and self-insured plans to provide 90 days of continued in-network care if a provider or facility leaves a network, to members who are undergoing treatment for a serious and complex condition, pregnant, receiving

inpatient care, scheduled for non-elective surgery or terminally ill. Blue Cross will comply with all applicable laws and regulations.

The enforcement of this section of the CAA will not occur until additional rulemaking occurs. To date, there has been no further guidance provided.

No Surprises: Price Comparison Tool (Section 114)

The legislation requires health plans to offer and maintain a price comparison tool and guidance for consumers by telephone or internet.

The Transparency in Coverage cost look-up tool is live and in production. Blue Cross will continue to make precision-enhancements to the tool throughout 2024. Additional support is available through our member service center.

UPDATE

Transparency: Pharmacy Benefit and Drug Cost Reporting (Section 204)

Fully insured and self-insured group health plans are required to report data annually to federal agencies on drug utilization and spending trends, including total spending for health care services and drugs covered under hospital or medical benefits. The report must include the following information:

- Prescription drugs that account for the most spending
- Drugs that are prescribed most frequently
- Prescription drug rebates from drug manufacturers
- Premiums and cost-sharing that patients pay

Blue Cross will provide different file submission details based on if the client has Prime Therapeutics or if the client carves out to another Pharmacy Benefits Manager (PBM).

To complete reporting requirements for the Pharmacy Benefits and Drug Cost Reporting, Blue Cross is launching a new Annual Client Survey on Blue Cross Connect for most clients.

Blue Cross submitted required reporting on June 1, 2023, for plan year 2022. The next reporting is due June 1, 2024, and we will be reaching out for data in February 2024 through the new process.

We value your business and are committed to provide updates on the CAA as needed. As always, please reach out to your Account Manager with any additional questions.

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The following information in this appendix consists of Sections of the CAA that have been implemented or need no further action.

No Surprises: Health Insurance Requirements regarding Surprise Medical Billing (Section 102):
Creates significant new requirements to address surprise billing applicable to fully insured, self-insured, FEP, and grandfathered plans. For covered emergency services at a hospital or freestanding emergency department, or free-standing emergency department, the plan must pay for services: (1) without requiring prior authorization; (2) without regard to the providers' network status; and (3) applying in-network cost-sharing.

Blue Cross will:

- Determine and apply the Qualified Payment Amount (QPA)
- Apply in-network benefits
- Direct payment to non-participating providers and will include a statement to the provider certifying that the QPA was determined in accordance with the interim final rules.

Blue Cross has a process in place effective January 1, 2022.

No Surprises: Determination of out-of-network rates to be paid by health plans; Independent Dispute Resolution process (Section 103):
After Blue Cross makes a payment pursuant to Section 102, this section describes how an out-of-network provider and Blue Cross can then negotiate the rate and, if they do not reach an agreement, to engage an independent dispute resolution (IDR) process. Plans and providers have 30 business days to negotiate payment, after the plan pays or denies a claim. If they do not reach an agreement, plans and providers have four days to initiate the IDR process.

Blue Cross will handle inquiries from Minnesota providers questioning the QPA and will be responsible for handling the IDR process. For out-of-state providers, the local Blue Plan may manage the IDR process.

No Surprises: Health Care Provider requirements regarding surprise medical billing (Section 104):
With exceptions, out-of-network providers may not balance bill a patient for items or services described in the CAA. Some providers may balance bill if they satisfy the notice and consent process established under the law. For those providers, Blue Cross will process the claim as member liability and continue to pay the provider directly. The notice and consent process, however, may not be used for certain services. This includes:

- emergency services
- certain ancillary services
- items or services delivered as a result of an unforeseen urgent need that arises during a procedure for which notice, and consent was received.

No Surprises: Health Care Provider requirements regarding surprise medical billing (Section 105):
Like Sections 102 and 103, but for air ambulance providers. For covered air ambulance services, the plan must pay for services: (1) without regard to the providers' network status; and (2) applying in-network cost-sharing. After initial payment, gives issuers and air ambulance providers 30 business days to negotiate an out-of-network payment, and if they do not reach an agreement, then either party may initiate an IDR process.

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No Surprises: Health Care Provider requirements regarding surprise medical billing (Section 105) continued:

Blue Cross will:

- Determine and apply the Qualified Payment Amount (QPA)
- Apply in-network benefits
- Direct payment to non-participating providers and will include a statement to the provider certifying that the QPA was determined in accordance with the interim final rules.

Blue Cross has a process in place effective January 1, 2022.

Under the No Surprises Act (NSA), effective for plan years beginning on or after January 1, 2022, group health plans and insurers are required to post (and include in all explanations of benefits (EOBs) to which the surprise billing rules apply) a one-page notice that provides information on the NSA, including contact information for appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Blue Cross began including the required notice with the Explanation of Benefits (EOBs) to which surprise billing rules apply, effective January 1, 2022. We also added the information to our member portals www.bluecrossmn.com/members/claims/no-surprises-act

No Surprises: ID Cards (Section 107):

The CAA legislation requires that as plans renew, on or after January 1, 2022, new ID cards be issued with additional information included. The new ID card has requirements intended to help members understand their deductibles and out of pocket expenses more clearly. While several ID card displays can remain unchanged (i.e., client logo, suitcase, back of the card customizations), Blue Cross must change all commercial lines of business ID cards to comply with the CAA mandate requirements and timelines. Blue Cross is required to issue physical ID cards versus digital only option.

Member ID Cards were updated, on our normal business timelines, to include:

1. Deductibles for in- and out-of-network amounts
2. Maximum out-of-pocket costs; and
3. Telephone number and website for a member to get assistance

Though the FAQ released by the departments in August 2021 indicates no new guidance would be issued prior to January 1, 2022, each benefit plan is still expected to make “good faith” effort to comply. Blue Cross worked with our partners to ensure we met the legislation as it is written, with the understanding that additional changes to the ID cards may be needed once additional rules are provided.

No Surprises: Provider Directories (Section 116)

Health plans must establish and maintain an online directory listing including the following provider information:

- Names of contracted provider
- Addresses
- Specialties
- Telephone numbers and digital contact information

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The information must be verified and updated at least every 90 days and updated in the directory within two business days of receiving new information from a provider.

The provider information is available and the first attestation by Minnesota providers is March 31, 2022. Providers need to attest to the accuracy of the information.

Transparency: Gag Clauses (Section 201):
This applies to fully insured and self-insured [products or plans] and prohibits gag clauses in provider agreements related to certain price and quality information.

Blue Cross does not have any gag clauses in our provider contracts.

Transparency: Disclosure of Direct and Indirect Broker Compensation (Section 202):
Requires broker and consultant compensation disclosure.

This requirement is not a health plan or carrier requirement but falls on the agents/brokers. Agents and Brokers should seek guidance from their trusted legal advisors on how to implement.

Transparency: Machine Readable Files
This section focuses on publishing pricing information via "machine readable files" for industry stakeholders and think tanks to use for overall review and analysis of the market. There is little direct member impact of this work.

Blue Cross publishes updates monthly to the Machine-Readable Files (MRF) on our website bluecrossmn.com/mrf and this includes links to the files required by federal agencies. The webpage contains:

- A link to our MRF pricing file(s) – which are large and intended for machine use
- Content explaining the MRF mandate
- Links to related government documentation on the MRF mandate
- An FAQ document that includes questions and answers we received regarding Machine Readable files (MRF)

We are producing monthly files for fully insured, self-insured and Third-Party Administrators (TPAs) on a public domain. There is no need for an agreement or a contract. Blue Cross is doing this work on your behalf, there is language in the service agreements at Article Three, Section 8 addressing regulatory compliance with laws (which would include the CAA), specifically that Blue Cross will comply with all legal requirements pertaining to the specific services and obligations it undertakes in the agreement. It's important to note the files are likely to continue to be enhanced over time.

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Transparency: Mental Health Parity (Section 203)

Blue Cross conducts comparative analyses and maintains documents regarding its processes, strategies, evidentiary standards, and other factors supporting compliance regarding Blue Cross's standard nonquantitative treatment limitations (NQTLs) for its fully insured lines of business, as required by the MHPAEA and amendments thereto, including the following:

1. Medical Management Standards; Medical Necessity and Experimental/Investigative Criteria
2. Prior Authorization Inpatient Requirements
3. Prior Authorization Outpatient Requirements
4. Concurrent Review Inpatient Requirements
5. Post-Service Medical Necessity Requirements (Post-Service Retrospective Review)
6. Appeals Process
7. Provider Reimbursement Methodologies Regarding Out-of-Network/Non-Contracted Providers
8. Standards for Provider Admissions to Participate in a BCBSMN Network, Including Reimbursement Rates
9. Fraud, Waste and Abuse/Special Investigations
10. Pharmacy - Formulary Design
11. Pharmacy - Prescription Step Therapy
12. Pharmacy - Preventable Covered Prescription Drugs
13. Pharmacy - Prior Authorization

Due to the evolving nature of the comparative analyses and continued guidance from the Department of Labor, Blue Cross will provide a summary of its most current comparative analyses upon request. Providing the most current comparative analysis will better serve the self-insured clients in conducting their own parity assessments of their plans. Blue Cross will provide its supporting document for its fully insured business' comparative analyses, most of which are confidential and proprietary, directly to the applicable regulator on behalf of the self-insured client, when needed. In providing this cooperation and assistance, Blue Cross does not assume responsibility for a self-insured plan's MHPAEA compliance or NQTL comparative analyses.

Consistent with the above, for all regulatory requests, please contact Blue Cross before producing any previously shared confidential and proprietary comparative analyses, and if your plan receives a request for NQTL comparative analyses from a regulator.