Transparency in Coverage Regulation and Consolidated Appropriations Act

External FAQs for Fully Insured and ASO including Anthem Balanced Funding (ABF)

Last Update: June 2022 (gray highlight indicates updates)

The information in this document does not constitute legal advice. Customers should consult their legal team for further questions or advice.*

Transparency in Coverage – Final Regulation

General

Anthem supports meaningful transparency efforts that help consumers make informed health care decisions. In August 2021, the Department of Labor, in conjunction with the Departments of Health and Human Services (HHS) and the Treasury, (known collectively as the "Tri-Agencies") issued updated guidance related to implementation of the Consolidated Appropriations Act (CAA) and Transparency in Coverage (TIC) final rule. The guidance delayed enforcement and provided good faith compliance safe harbors related to the implementation of a number of provisions of the CAA and TIC. It is important to note, requirements related to the surprise billing provisions remained unchanged.

Due to the operational complexities and timeline challenges, the enforcement of key provisions including the prescription drug machine-readable file, advance explanation of benefits, and the price comparison tool – has been deferred pending further guidance. This delayed enforcement provides much needed additional time to implement the requirements, while giving the Tri-Agencies time to align overlapping requirements and provide technical guidance for public comment and rulemaking.

The TIC regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, Health Plans must expand those tools to cover all items and services by January 1, 2024. The rule also requires Health Plans to make public machine-readable files (MRF) beginning on July 1, 2022 (delayed from January 1, 2022) that contain the negotiated rates with in-network providers for all covered items and services as well as historical payments to and billed charges from out-of-network providers. The requirement to post an MRF containing the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level has been deferred until further notice and comment rulemaking. The purpose of the rule is to provide transparency that federal regulators believe will promote consumer choice

and competition among providers.

Anthem is not amending its fully insured contract to reflect these laws, since there is a standard provision stating Anthem will comply with applicable law. Anthem will be updating Certificates of Coverage as needed, depending on state law, to inform members of their benefits under these laws.

Anthem is amending the ASO agreement as described at the end of this FAQ to incorporate the services Anthem will be providing under the Regulation and CAA.

What areas will Anthem take responsibility for and make updates to be in compliance?
Anthem has developed an implementation strategy for achieving the Transparency requirements, the intent of which is to provide a compliant solution which applies equally to fully insured and self-funded (ASO) clients for the data we administer and maintain.

How will carve-out situations be handled?
In situations where a group has a vendor other than Anthem for certain services (e.g., Pharmacy), Anthem's pricing and rate information will not apply to the services supplied by the third-party vendor.

Will Anthem be amending par-provider contracts to allow for the disclosure of rates for the purpose of satisfying the transparency requirements?
Anthem's participating provider contracts permit the disclosure of proprietary information where required by law or regulation, but only as it relates to the scope of the specific mandate and not beyond what is required by law.

What areas does Anthem feel are already in compliance with no change needed? Where are the current tools relative to the requirements as they are outlined by effective dates?
While Anthem does have member transparency tools, such as Find Care and the Sydney app, in place and available currently for much of our business, changes will be required based on the current language in the Regulation.

Will there be a cost for hosting the platforms or providing the data?
There will be no additional charge for this specifically. However, the new regulations will be taken into consideration when determining our administrative fees.

Will you support the employer's communication to their employees on these changes and new resources?
We do anticipate communicating with employers as to our implementation activities for these laws. Employers may use these communications to develop communications for their employees.

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are issued.

Machine-Readable Files

What is a machine-readable file?
A machine-readable file is defined as a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost. The final rules require each machine-readable file to use a non-proprietary, open format. The machine-readable files for the data we administer and maintain will be made accessible through anthem.com. Employers can link to those files; but due to the size of the files, we will not be providing the data directly to our clients for them to put on their websites. Anthem will only be publishing the data it maintains, so if a plan uses a third-party vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

How often will the machine-readable files be updated?
The files will be updated monthly on the first of each month.

Will you create these files and/or the website internally or utilize a subcontractor? If you are using a subcontractor, will you offshore?
We will create these files internally.

Will you only provide your data, or will your platform allow for merging other vendor's data (e.g., PBM, specialty network, etc.)?
We will only provide the data we administer and maintain.

Will the publicly available files be accessed through the current participant portal or be located in a new portal? Will you provide the files to plan sponsors or can plan sponsors link to the files?
These files will be accessible through anthem.com on a publicly available website. Due to the size of the files, we will not provide the data directly to our clients. Plan sponsors may link to those files as desired.

How will you monitor and validate your processes to ensure the ongoing accuracy of the data in the files?
Quality Audit (QA) processes will be an integral part of our solution design for the monthly file postings.

When will your platform be ready to launch?
We are targeting a July 1, 2022 launch as defined in the August 2021 FAQ from the Tri-Agencies.

How will client-specific machine readable files be accessed on anthem.com?
Beginning July 1, Anthem will publish the machine readable files for the plans we administer and maintain. These files will be published on anthem.com and can be accesssed using this link: (https://www.anthem.com/machine-readable-file/search). This link can be added to the group health plan's public website to fulfill the group health plan posting requirement. This link will allow you to search for your files using your Employer Identification Number (EIN).

What is an Employer Identification Number (EIN)?
An Employer Identification Number (EIN) is a unique nine-digit identification code issued by the Internal Revenue Service (IRS) to a business. The CMS file layout requires group rate information to be loaded using the group EIN.

Will employers be able to obtain test data and/or test files from Anthem prior to July 1, 2022?
No, we are not planning any external testing. Testing will be conducted internally by Anthem. Quality Assurance processes will be an integral part of our solution design. Prior to file publication, we will communicate to clients how to identify and access their data within the files.

Please describe how your organization will respond to questions regarding any missing values such as NPI, procedure codes, etc.
Those processes have been determined as a part of our design process.

Will you provide the plan with any of the three machine-readable files on a monthly basis including in-network rates, out-of-network allowed amounts, and prescription drug negotiated rates (for drugs dispensed under the medical plan)?
No, due to their size, the machine-readable files will only be made available on anthem.com.

Cost Transparency Tool

The Transparency in Coverage regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services, health plans must expand those tools to cover all items and services by January 1, 2024.

The CAA also requires plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

On August 20, 2021, the Tri-Agencies announced delays in enforcement of key provisions of the CAA. Specifically, enforcement of the price comparison tool mandate is delayed until January 1, 2023. The intent is to align the requirements of the Regulation with the Cost Price Comparison tool requirements of the CAA. Additional rulemaking guidance is anticipated.

How will Anthem make the tool available to plan participants? Through your website, by providing information to plans, or through another option?
The tool will be made available through our website and mobile applications.

How will you respond to individuals who request the information on paper or by telephone instead of through the website?
Requests for information on paper or by telephone will be handled by Member Services.

Consolidated Appropriations Act (CAA) - Law pending final regulations

General

The CAA represents the most significant changes to the private insurance market since the Affordable Care Act (ACA). The law:

- Requires plans to develop and make available price transparency tools, good faith estimates

and an advanced explanation of benefits
- Restricts “surprise billing”
- Prohibits “gag clauses” in healthcare contracts
- Adds new mandates for ID cards, provider directories and continuity ofcare.

These provisions are described in more detail below but note that much of the important detail of this law will be determined by regulations that will be released over the next several months. Anthem is working alongside other stakeholders to assess the operational complexities and timelines for implementation and continues to make recommendations to the Tri-Agencies who must develop these regulations.

Who does this law apply to?
All types of employer plans, including self-funded employers as well as health insurance issuers in the individual and group markets.

What is the effective date of the law?
The CAA included numerous provisions, the majority of which become effective January 1, 2022.

On August 20, 2021, the Tri-Agencies announced delays in enforcement of key provisions of the CAA. Specifically, enforcement of the price comparison tool mandate is delayed until January 1, 2023. The requirement for plans to provide a good faith estimate of charges and an Advance Explanation of Benefits (AEOB) when notified of a scheduled service by a provider are delayed, pending future regulatory guidance, with no final date set.

The Tri-Agencies also announced they would issue regulations to implement the ID card, provider directory, gag clauses on price and quality data, and continuity of care requirements, but would not do so prior to January 1, 2022. Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

How does the Transparency in Coverage regulation relate to the transparency requirements included in the “No Surprises Act” aka the Consolidated Appropriations Act (CAA) published at the end of 2020?
These two separate laws make sweeping changes to the healthcare industry in an effort to further promote transparency. Although separate, they include overlapping provisions, notably the price comparison tool requirements.

The Regulation requires health insurers and group health plans to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services; Health Plans must expand those tools to cover all items and services by January 1, 2024.

The CAA also requires a price comparison tool; however, the requirements are not nearly as detailed as the tool considered under the Transparency in Coverage regulation. It still requires insurers to publish a tool for members allowing comparison of cost sharing amount for covered items and services.

The CAA also includes other transparency initiatives beyond the Transparency in Coverage requirements including:

1. Out-of-network providers to deliver to the patient's health plan a "good faith effort of an estimated amount" of all billing and services;
2. Providers to make available on their publicly available website information on their pricing for services;
3. Health Plans to provide members with an Advanced Explanation of Benefits (AEOB) prior to scheduled care or upon patient request;
4. Health Plans to maintain up-to-date provider directories; and,
5. Health Plans to remove gag clauses in their par-provider contracts.

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of certain provisions of the CAA. Specifically, enforcement of the price comparison tool requirements in the CAA and are delayed until January 1, 2023, to align with the Transparency in Coverage regulation effective dates. The Tri-Agencies will use the delay to propose rules and seek public comment regarding whether compliance with the Transparency in Coverage regulation would satisfy the requirements to create a price comparison tool under the CAA.

Are there any elements of the regulations that may not be satisfied by Anthem that would result in a compliance gap for employers to address on their own?
Transparency in Coverage Regulation – Anthem is developing an implementation strategy for achieving the Transparency requirements, the intent of which is to provide a compliant solution which will apply equally to fully-insured and self-funded clients for the data we administer and maintain. Any client-specific requests will be considered separately, and an additional cost may apply. If a client carves out any portion of their business or uses another vendor for pricing or processing, the client will need to work with the other vendor/insurer to obtain or provide that data.

CAA – This has not been determined. Much of the important detail of CAA provisions will be determined by regulations that will be released over the next several months. Anthem is working alongside other impacted stakeholders to assess the operational complexities and timelines for implementation and continues to make recommendations to the Tri-Agencies. We will provide updates as regulations are published for comment.

Do the CAA and Transparency requirements have any pricing impact to premium/administrative services fees?
At this time, we do not anticipate a direct cost to the client for standard compliance with this provision, except for the surprise bill/IDR process described below for our ASO clients, however the new regulations and laws will be taken into consideration when determining our administrative fees or premium rates we charge our clients.

How will Anthem make additional quality data available to supplement/complement the requirements – and how/when will changes occur going forward?
QA processes will be an integral part of our solution designs.

Will you support the employer's communication to their employees on these changes and new resources?
We do anticipate communicating with employers as to our implementation activities for these laws. Employers may use these communications to develop communications for their employees.

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are finalized.

CAA Price Comparison Tool

The CAA requires Health Plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

On August 20, 2021, the Tri-Agencies announced delays in enforcement of key provisions of the CAA. Specifically, enforcement of the price comparison tool mandate is delayed until January 1, 2023. The intent is to align the requirements of the Transparency in Pricing regulation with the Price Comparison tool requirements of the CAA. Additional rulemaking guidance is anticipated.

Provider Directory

The CAA requires Health Plans to establish a verification process to confirm provider directory information at least every 90 days and establish a procedure to remove providers or facilities who are non-responsive. Health Plans must also develop a response protocol to respond to member network questions. Members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing.

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the provider directory requirements but would not do so prior to January 1, 2022. Health Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date with a primary focus on ensuring members who rely on provider directory information that inaccurately depicts a provider's network status are only liable for in-network cost sharing amounts. Anthem is moving forward with a focus on that good faith compliance while awaiting additional regulatory guidance.

Will a provider directory be available and kept up to date?
Yes.

Will directory be available electronically and/or printed?
Yes.

For your ASO clients, will you accept responsibility for directory inaccuracies resulting in added plan cost?
The Administrative Services Agreement's indemnification provision will apply.

Will you comply with the provider directory requirements on behalf of your employer clients?
Yes, however, much of the important detail of CAA provisions will be determined by regulations that will be released over the next several months.

How often will you update the directory?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

Will you notify employers of the update?
No.

Will the versions be dated, so employers will know the updates are current?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

How will access to the directory be provided (i.e., directly or via an employer website)?
The provider directory is/will be available through our website.

Mental Health Parity

What do the Strengthening Parity in Mental Health (MH) and Substance Use Disorders (SUD) provisions do?
Included as part of the CAA were several measures intended to strengthen parity in MH/SUD benefits, specifically with Non-Quantitative Treatment Limitations (NQTLs). Importantly, if a group health plan that provides both Medical/Surgical (MS) benefits and MH/SUD benefits and imposes NQTLs on MH/SUD benefits, the plan has to perform testing and make testing results available to the Tri-Agencies, or any state authority, upon request within 45 days of enactment of the CAA (generally, no later than February 10, 2021). Plans must also document and make available the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and MS benefits to which each such term applies in each respective benefits classification.
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and MS benefits.
3. The evidentiary standards used for the factors identified in 2 above when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and MS benefits.
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MS benefits in the benefits classification.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described above that indicate that the plan or coverage is or is not in compliance.

The Mental Health Parity and Addiction Equity Act (MHPAEA) currently requires NQTL testing, but the CAA creates more formal analyses and reporting. The DOL can begin requesting a comparative analysis report from group health plans beginning on February 10, 2021. The DOL will be issuing regulations on these new requirements.

What is a Non-Quantitative Treatment Limitation (NQTL)?
Mental Health Parity law looks at two types of treatment limitations – quantitative and non-quantitative. Quantitative treatment limitations are the limits that apply to the coverage in the benefit booklets, such as cost-sharing and visit limits. Non-quantitative treatment limitations are behind-the- scenes administrative activities that take place but may impact coverage. Examples include credentialing, how Health Plans determine the amounts to pay providers, utilization management, creation of medical policies and case management. The law requires that Health Plans treat behavioral health conditions no less favorably than we do medical conditions.

Who does this law apply to?
The law applies to all types of group plans, including self-funded employers, as well as health insurance issuers in the individual and group markets. The only commercial products that are not affected are small group grandmothered and grandfathered plans. It does not apply to most Medicare plans or retiree-only group plans.

How will Anthem comply with this law?
Anthem has created NQTL analysis for its standard processes and procedures (e.g., Credentialing, Case Management, Utilization Review, etc.), which are available free of charge upon request.

Are you able to conduct and provide a detailed written comparative analysis of the design and application of the Non-Quantitative Treatment Limitations (NQTLs) as contemplated by the Consolidated Appropriations Act?
Yes, for the services for which Anthem utilizes its standard policies and procedures. Anthem has used the DOL self-compliance tool to analyze its compliance with the NQTL requirements.

Does the Anthem NQTL analysis apply to all plans subject to the law, whether fully insured or self-insured grouped?
The NQTL analysis applies to all fully insured business. To the extent a self-funded group utilizes Anthem's standard processes and procedures for the administration of its Health Plan (e.g., credentialing), Anthem's NQTL summaries will be applicable to any inquiries. However, if a group deviates from Anthem's standard procedures (e.g., modifies the prior authorization list) or doesn't use Anthem as a vendor for all of its plan administration (e.g., Pharmacy), then NQTL analysis would be the responsibility of the group or its other vendor(s).

Will Anthem provide required documentation for ASO clients?
Anthem will provide our NQTL analysis upon request, which reflects our standard processes and procedures. This NQTL analysis can be provided to groups, members, regulators or providers. It will be updated periodically. However, Anthem will not provide any analysis for NQTLs that are within the group's responsibility (e.g., benefit exclusions, Pharmacy with a non-Anthem vendor, etc.).

Will Anthem perform the NQTL test for ASO groups?
If a group uses our standard policies and procedures, our existing NQTL analysis will apply to them and no group-specific testing is needed. For other NQTLs that are solely within the group's control (e.g., benefit design) or a requested deviation from our standard process (e.g., change to preauthorization listing), the group would be responsible for the NQTL analysis because they know why they made that determination. Also, if a group uses a vendor other than Anthem for an applicable NQTL, such as carved out pharmacy services, then the group will need to work with that vendor for any NQTL analysis.

Advance Explanation of Benefits (AEOB)

The CAA requires health plans to provide an advance explanation of benefits (AEOB) for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of those providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates.

On August 20, 2021, the Tri-Agencies announced an indefinite delay in enforcement of the AEOB requirements. No new enforcement date was set.

Surprise Medical Billing

The CAA includes the "No Surprises Act" which mandates that patients are only responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The law also prohibits providers from balance billing except in limited circumstances with patient notice and consent. The act also requires an independent dispute resolution process for providers and plans who cannot reach an agreement on payment.

Much of the important detail of these provisions will be determined by regulations that will be released over the next several months. The information provided below incorporates the regulations that were issued on July 1, 2021, and September 30, 2021.

What is the Qualifying Payment Amount (QPA)?
The QPA is the lesser of the median contracted rate in the metropolitan service area (MSA) for same or similar services and a same or similar provider or billed charge.

Will Anthem determine the Qualifying Payment Amount?
Yes, Anthem will determine the QPA.

How will Anthem define and evaluate service codes for purposes of determining the QPA?
Anthem will use the definitions outlined in the IFR. Service code means the code that describes an item or service, including a Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Code. Given the requirement that a separate QPA be established for each Service Code, Revenue Codes may also be considered Service Codes under the outpatient methodology.

Will Anthem determine a QPA for an individual ASO customer?
No, the IFR defines insurance market to include all self-insured group health plans administered by the same third-party administrator for purposes of determining the QPA. Network offerings are not differentiated among Anthem's self-funded and large group fully insured customers, so those segments were combined for purposes of determining the QPA.

How will member cost sharing be determined for use of out-of-network providers/facilities when surprise billing criteria is met?
Anthem will use the QPA to determine the member cost share. Member cost share will be based on

the lower of the QPA or provider billed charge.

Does the No Surprises Act apply to ground ambulance as well as air ambulance?
No, the law applies only to air ambulance.

The CAA will require health plans to reimburse out-of-network (OON) providers and facilities in the situations where balance billing is prohibited. Will Anthem be offering services to support this?
Yes, Anthem is prepared to pay the provider directly where applicable.

Are there any state laws that affect your determination of the recognized amount? If so, please describe.
State surprise billing laws will continue to apply to the state's fully insured business and in situations where ASO groups have opted-in to the state law. The Federal "No Surprises Act" will apply to self-funded business and fully insured business in states where there are no surprise billing laws.

How will negotiation and arbitration be handled?
We will negotiate with OON providers for our ASO and fully insured clients. However, an ASO group will be charged any fees related to IDR arbitration. This chargeback is not applicable to fully insured clients.

Will your organization handle arbitrations with out-of-network providers that do not accept the plan's out-of-network rate?
Yes, however for ASO clients, there will be a chargeback to the client for the IDR fees. This chargeback is not applicable to fully insured clients.

Do you have a list of certified IDR entities?
The list of certified IDR entities is available at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

What can the client expect in regard to IDR fees and expenses?
According to the Surprise Billing interim final rule issued on September 30, 2021, the following are the ranges of fees that can be expected – see https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Technical-Guidance-CY2022-Fee-Guidance-Federal-Independent-Dispute-Resolution-Process-NSA.pdf

- For the calendar year beginning January 1, 2022, the administrative fee due from each party for participating in the Federal IDR process is $50. In future years, estimated costs will be informed by the actual costs incurred by the Departments to carry out the Federal IDR process.
- The average certified IDR entity fee will be approximately $400.
- For the calendar year beginning January 1, 2022, certified IDR entities must charge a fixed certified IDR entity fee for single determinations within the range of $200-$500, unless otherwise approved by the Departments pursuant to section IV of this guidance.
- If a certified IDR entity chooses to charge a different fixed certified IDR entity fee for batched determinations, that fee must be within the range of $268-$670, unless otherwise approved by the Departments pursuant to section IV of this guidance.

- Under no circumstances may a certified IDR entity charge a party for additional costs beyond the certified IDR entity fee and administrative fee.

Will the IDR Fee be charged to the ASO client under the claims account or as a direct charge to the client?
The IDR Fee will be direct billed.

If the IDR Fee is billed up front and the plan sponsor is determined to be the prevailing party, would the fee be refunded to the ASO client?
The administrative IDR fee is not refundable. It is a charge by the Federal Government to use the Federal website and process. The Arbitrator Fee or CIDRE Fee will only be charged to the client if the provider prevails in arbitration or if the dispute is settled before the arbitrator's decision.

How will these fees show on the ASO client invoice?
They will be in the summary section and broken down in the detail section as well.

What type of reporting on IDR cases will be available to ASO clients?
We will provide both a summary and per member detail of Administrative and Arbitrator fees on the monthly bill when they occur. We are considering other types of reporting in the future and welcome our clients' input on what information would be valuable.

Is there a defined timeline for the Negotiation and IDR Process?
Yes, CMS defines a specified timeline for the negotiations and IDR process including a 30 business day open negotiation period prior to IDR. See the link below for details on the timeline: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

Will you post the required disclosure notice on your website and include it on Surprise Bill member Explanation of Benefits (EOBs) beginning 1/1/22?
Yes. We posted a notice to our site that will meet the mandated requirements and will also be included with applicable Explanation of Benefits (EOBs) beginning 1/1/22. The client can choose to link to our notice. In regard to an ASO client, each entity is responsible for posting on their site as they deem appropriate.

Where on the public site will the model notice be placed?
The notices have been posted at the following website: www.anthem.com/no-surprise-billing

ID Card Requirements

The CAA requires health plans to provide information on ID cards in a clear and understandable manner regarding 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 August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the ID card requirements but would not do so prior to January 1, 2022. Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date. The Tri-Agencies advised they were aware of the challenges for the plans with

complex benefit structures, and provided elements to determine compliance, including the usage of a website where information was not included on the face of the ID card.

Will ID cards be able to include INN/OON deductibles and OOP limits?
Anthem will add verbiage to member ID cards advising the member where they can retrieve helpful, easy to understand information regarding their benefits. This information will include up to date in- and out-of-network deductibles and out-of-pocket maximums.

Will ID cards be able to include provider directory contact info?
ID cards currently include a telephone number and Internet website address through which an individual may seek consumer assistance information, such as information related to providers that are participating in their network.

When do you need renewal decisions in order to produce new cards in a timely fashion?
Anthem will make the required changes to any impacted ID cards that we issue with effective dates from January 1, 2022, and forward. ID cards will continue to be issued when required (e.g., any changes necessitating reissuance). For any needed reissuance for plan years on or after January 1, 2022, the changes will be incorporated in our administrative fees.

Given the new guidelines to display in-network (INN) and out-of-network (OON) cost-sharing requirements, we presume the new ID cards need to be issued. Please confirm Anthem's ability to support this and expected timing.
Anthem will include a message directing the member to anthem.com for detailed benefit information that provides INN/OON cost-sharing requirements. We will make the required changes to any impacted ID cards that we issue with effective dates from January 1, 2022, and forward. ID cards will continue to be issued when required (e.g., any changes necessitating reissuance). For any needed reissuance for plan years on or after January 1, 2022, the changes will be incorporated.

CAA Pharmacy and Other Health Reporting

The Consolidated Appropriations Act requires health insurers offering group or individual health coverage and self-funded (ASO) group health plans to report annual data to the Tri-Agencies on drug utilization and spending trends. The reporting must include total spending on healthcare services by type, such as for hospital, primary care, or prescription drugs. The reporting must also include rebate information and its effect on member costs.

The required reporting templates include:

- Plan Lists (Individual and Student, Group Health Plan List, and FEHB Plan List)
- Data Files (reporting of aggregated data based on state and market segment)
    - Premium and Life-Years Reporting
    - Spending by Category Reporting
    - Top 50 Most Frequent Brand Drugs Reporting
    - Top 50 Most Costly Drugs Reporting
    - Top 50 Drugs by Spending Increase Reporting
    - Rx Totals Reporting
    - Rx Rebates by Therapeutic Class Reporting

- Rx Rebates for the Top 25 Drugs Reporting

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of the pharmacy reporting requirements until the issuance of new regulations. The new compliance date is December 27, 2022 for reporting years 2020 and 2021. Future years reporting will be due on June 1 annually (i.e., 2022 data will be due on June 1, 2023).

An Interim Final Rule was issued on November 17, 2021, including instructions for this reporting. While some implementation detail is still pending, Anthem is moving forward with development of the required reporting for the data we administer and maintain while continuing to monitor for additional regulatory guidance. We will also continue to work with CMS and other impacted stakeholders to make recommendations to the Tri-Agencies in areas where the reporting requirements are unclear or reporting includes data that is not maintained by issuers.

According to the reporting instructions, the reports may be submitted by different entities based on the information required in the report. For example, for a self-funded group, the TPA or Medical Issuer may submit the Spending by Category reporting, while the PBM submits pharmacy related reports such as the Top 50 Most Costly Drugs report.

Will Anthem submit the reporting to HHS?
Anthem will submit the aggregated reporting data on our fully insured and ASO clients' behalf for the benefits we administer and maintain. This will include submission of the pharmacy data through IngenioRx for clients that have integrated pharmacy with IngenioRx through Anthem. If a client has a carveout vendor for any portion of the required data (e.g., carveout PBM, Stop Loss Carrier), the client should work with the carveout vendor to ensure submission of that data.

Will you submit the data individually by client?
No, according to the instructions, issuers are to submit the report in aggregate (combining all data) for each reporting entity and market segment. For example, a reporting entity such as a medical issuer that is submitting the Spending by Category report, would aggregate all of the data for each applicable market segment.

How does HHS define the market segments for reporting?
The market segments for reporting include: Individual, Student, Small Group, Large Group, Self-Funded Small Employer Plans, Self-Funded Large Employer Plans, FEHB Plans.

Where are the reports to be submitted?
Reports are to be submitted to HHS through their Health Insurance and Oversight (HIOS) system. HIOS is an application within the CMS Enterprise Portal https://portal.cms.gov/portal/.

Prohibition on Gag Clauses

The CAA prohibits so-called "gag clauses" in health plan participating provider contracts. These contract provisions prohibit payers from disclosing provider-specific cost or quality information.

On August 20, 2021, the Tri-Agencies released FAQs noting they will not issue any regulations on gag clauses as it is self-implementing. Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date. Anthem's

ASO contracts include provisions that each party will comply with applicable law. Accordingly, to the extent the existing contract could be interpreted to include a gag clause, this law would eliminate that prohibition.

Have your participating provider contracts been revised to remove any language that restricts cost information sharing except for reasonable restrictions as permitted by the CAA, to allow plan sponsors to complete the attestation required?
Our provider contract templates do not contain language that restricts the disclosure of cost information. However, there are negotiated contracts that do contain such restrictions. Anthem is evaluating these restrictions. Anthem's provider contracts also require compliance with the law. Anthem has sent a notice to our providers reminding them of the CAA provision on gag clauses and the obligation of both health plans and providers to comply with the law.

Are there restrictions that will not be revised in time to meet the statutory deadline?
There are no known restrictions at this time.

Will Anthem prepare the attestation on behalf of fully insured and ASO clients?
This is to be determined. The Departments intend to issue implementation guidance to explain how plans and issuers should submit their attestations of compliance and anticipate beginning to collect attestations starting in 2022. We will provide additional detail once regulatory guidance is received.

Continuity of Care

The CAA requires Health Plans to provide in-network coverage for 90 days of continued care to members whose provider or facility leaves the health plan's network when the member is undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non- elective surgery, or terminally ill.

On August 20, 2021, the Tri-Agencies released FAQs noting that they will issue regulations to implement the continuity of care requirements but will not do so prior to January 1, 2022. Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date. Anthem is moving forward with a focus on that good faith compliance including enhancing the current process in which a member receives notice when a provider they have seen in the past year leaves the Anthem network. We will continue to monitor for additional regulatory guidance.

Does a Do Not Contact provision in a contract prevent Continuity of Care letters from being generated to potentially impacted members?
No, Federally mandated communications are required to be sent regardless of any Do Not Contact contract provisions.

State All Claims Payer Databases

Please share Anthem and its affiliated health plans' intention to comply with the Secretary of Labor's standardized reporting format for voluntary reporting to State All Payer Claims Databases. Please comment on your expected timing according with the new regulations. Please delineate the impact, if any, on the administrative fees as a result of these changes.

We currently have plans in multiple states with All Payer Claims Databases (APCD) existing or in implementation phases (e.g., California, Connecticut, Indiana, Georgia, Maine, New York, New Hampshire, Virginia). Anthem and its affiliated health plans submit data pursuant to each state's requirements. Additionally, Anthem and its affiliated health plans intend to submit data to any other states creating an APCD and utilize the standard format where applicable. Specific information regarding satisfaction of this requirement, including additional costs, is unavailable at this time as the format and state adoption is currently unknown.

Air Ambulance Reporting

A proposed regulation on the Air Ambulance reporting provision of the Consolidated Appropriations Act was issued on September 16, 2021, with a request for comments/feedback. The reporting itself is proposed to be due in March 2023 and would reflect 2022 data. Our teams are in the process of reviewing the requirements in the proposed regulation and will have more information to share on reporting expectations once the final regulation is issued.

Agent/Broker Disclosures

Included as a part of the CAA were provisions related to Broker and Consultant Compensation disclosure and reporting. These provisions require brokers and consultants to disclose to group health plan sponsors any direct or indirect compensation they receive for brokerage services or consulting. For individual health insurance coverage and short-term limited-duration insurance coverage, a health insurance issuer must disclose to enrollees, and report to the Dept of Health and Human Services (HHS), any direct or indirect compensation that the issuer pays to an agent or broker associated with the plan section and enrolling individuals in the coverage.

Who is responsible for disclosure and reporting of the compensation?
For group business, the Broker or Consultant (including their affiliates and subcontractors) is responsible for disclosure and reporting. For individual business and short-term limited-duration business, the insurer is responsible for disclosure and reporting.

A proposed regulation specific to the requirements for disclosing and reporting Agent/Broker compensation for individual and short-term limited-duration business was issued on September 16, 2021, with a request for comments and feedback. Anthem has provided feedback on the proposed regulations to CMS and is developingthe individual and short-term limited-duration business compensation disclosure based on the proposed regulation guidelines.

ASO Agreement Amendment

The Administrative Services Agreement will be amended to reflect the changes to the services Anthem provides as of January 1, 2022. The actual amendment to the Administrative Services Agreement, including the provisions below, will be provided at renewal on or after January 1, 2022. If the agreement happens to include a term, provision, or section that differs from that below, please know these provisions below are still considered to be incorporated into the agreement and any discrepancies will be addressed through the full amendment that will be provided at renewal on or after January 1, 2022. As a courtesy, to assist in identifying the changes, we have indicated the additions by using italics:

Article 1, Paid Claim Definition, subparagraph (5):

5. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory, or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of ~~Anthem's billing~~ dispute resolution procedures ~~with a Provider or Vendor~~. Any Claims paid pursuant to this provision will count towards any stop loss accumulators under a stop loss agreement with Anthem.

A new Article 2(b)(4) is created that reads as follows:

4. Administration of independent dispute resolution processes for non-Network Provider Claims (including non-network air ambulance Provider Claims) as set forth under the Consolidated Appropriations Act if listed in Schedule A for the fee set forth in Section 3.C of Schedule A. Employer agrees to promptly notify Anthem if an independent dispute resolution request is received. Failure to promptly notify Anthem may impact independent dispute resolution processes. Notwithstanding anything to the contrary in the Agreement, Employer shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by Anthem as part of Inter-Plan Arrangement Claim independent dispute resolution processes.

A new Article 2(aa) is created that reads as follows:

aa. Anthem shall provide reporting as indicated in Schedule B to assist with compliance under the Consolidated Appropriations Act.

Section 3.C of Schedule A is amended to add:

Fees and Costs for Independent Dispute Resolution. Notwithstanding anything to the contrary in the Agreement, Employer shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by Anthem as part of independent dispute resolution processes.

Schedule B is amended to add:

Other Services Required by Federal Law (as of the applicable effective date):

- *Advance explanation of benefits upon Provider request*

- *Price comparison tool access*
- *Continuity of care administration for Provider termination from the network*
- *Air ambulance Provider reporting*
- *Upon request, Anthem will provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Employer in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.*
- *Posting of machine-readable files for the services Anthem administers for the Plan on anthem.com.*