



Nonprofit corporations and independent licensees  
of the Blue Cross and Blue Shield Association

## Consolidated Appropriations Act of 2021 and Payer Transparency Frequently asked questions

### Background

At the end of 2020, the United States federal government passed the Consolidated Appropriations Act of 2021. Within the provisions of this Act, there were several that directly affected health insurers and health plans. This FAQ offers questions and answers for our groups about the various provisions. It also includes information related to Payer Transparency regulations that are not part of the CAA.

The document will be updated as more information is available.

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*The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice. As required by US Treasury Regulations, we also inform you that any tax information contained in this communication is not intended to be used and cannot be used by any taxpayer to avoid penalties under the Internal Revenue Code.*



## **Mental Health Parity – Nonquantitative Treatment Limitations**

### **1. What’s mental health parity?**

Mental health parity laws require insurers and plan sponsors (self-funded groups) that provide both medical surgical and behavioral health benefits (mental health and substance use disorder benefits) to ensure that financial requirements and treatment limitations for behavioral health benefits are not more restrictive than medical surgical benefits.

### **2. What are QTLs and NQTLs?**

Mental health parity is measured in two ways: quantitative treatment limitations (QTLs) and nonquantitative treatment limitations (NQTLs).

Quantitative treatment limitations are things like deductibles and copayments or treatment limitations (e.g. a cap on the number of visits or days of coverage). These are numerical or quantitative measures of how benefits are applied.

Nonquantitative treatment limitations are things like prior authorization requirements or medical necessity criteria. These are limitations that can’t be quantified or counted, but still impact how benefits are applied.

The Consolidated Appropriations Act 2021 requires insurers and plan sponsors to compare how NQTLs are developed and applied with respect to medical/surgical and behavioral health benefits. For example, how does the plan determine when a prior authorization is required? Does it make the decision based on certain factors (such as cost or high volume of claims)? Does it apply the same factors in the same way for both medical surgical and behavioral health benefits??

The comparative analyses review NQTLs and provide discussion of whether those NQTLs developed and applied to behavioral health benefits are comparable to and no more restrictive than similar limitations on medical surgical benefits.

### **3. Will Blue Cross Blue Shield of Michigan conduct a comparative design analysis and application of NQTLs along with the information below?**

- Specific plan/coverage terms regarding NQTLs and a description of how these terms apply to MH/SUD benefits and medical/surgical benefits in each classification.
- Factors used to determine that NQTLs will apply to MH/SUD benefits and medical/surgical benefits.



- Evidentiary standards used for these factors, as well as any other source or evidence relied upon to design and apply NQTLs to MH/SUD benefits and medical/ surgical benefits.
- Comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD benefits as written and in operation are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to medical/surgical benefits in the same classification; and
- The specific findings and conclusions reached in any analysis conducted as described above that indicate that the plan is or is not in compliance with MHPAEA.

Blue Cross created a toolkit for our self-insured groups and their consultants that is available upon request. The toolkit includes the following:

- An overview of how Blue Cross approaches mental health parity
- A summary of the NQTLs that are the Department of Labor's (DOL) near-term focus
- A benefit comparison based on our underwritten plans
- The group's member handbook

**4. Will analysis support be provided to self-insured clients?**

Blue Cross will provide support upon request if a self-funded client has a question on the interpretation of a specific benefit or NQTL.

**5. Will the analysis incorporate any client-specific designs or focus solely on the carrier's standard design?**

The toolkit is based on Blue Cross' underwritten book of business. It is not client-specific with respect to self-funded groups. See above for contents of the toolkit.

**6. Is Blue Cross prepared to comply with any request for this analysis by self-insured clients immediately?**

Blue Cross has made the toolkit available to self-funded clients and it will be updated as our analysis continues.

**7. Will Blue Cross be able to prepare a report or comparative analyses as outlined in the FAQs dated April 2, 2021 in the question #2 and include a robust discussion of the nine elements listed?**

Blue Cross has updated our internal analyses for our underwritten HMO and PPO plans based on the April 2<sup>nd</sup> FAQs. The review includes the nine elements the DOL requires for "sufficient" response.



Blue Cross has also updated the original PPO toolkit, using the FAQs as guidance. We are in the process of finalizing the HMO toolkit, which will be available shortly.

**8. Will there be an additional cost for self-insured clients for this analysis and documentation?**

As of this date, there is no additional cost for the toolkit.

**9. For clients who may have a carve-out mental health vendor, will there be coordination with that vendor to complete this analysis?**

Blue Cross will provide reasonable assistance to self-funded clients and their vendors.

**10. Since health insurance carriers have a direct obligation to comply with the requirements, will Blue Cross make the results of the analysis available to our fully insured clients?**

In the event of an audit, Blue Cross will share its results as required.

**11. Do you estimate an increase in the premium amounts to fully insured clients due to these requirements?**

Blue Cross does not currently estimate an increase in premium amounts for our fully insured groups due to the MHP NQTL requirements.

**12. Have you found any difference in NQTLs between Simply Blue and Community Blue certificates?**

Blue Cross reviewed NQTLs under the Community Blue certificate. Most NQTLs apply across all certificates (i.e., medical and utilization management, formulary and tier designs, network admission standards, provider reimbursement, and appeals); prior authorization requirements may vary across different certificates.

**13. If the Department of Labor conducts an audit and additional information is required, more details, etc. Will Blue Cross support the group in providing details on how they are administering the plan for an ASC client?**

In the event of an audit, Blue Cross will provide support to our self-funded customers.

**14. How confident are you that the NQTL comparison is sufficient? It seems to make some general statements, but lacks specific examples.**

Blue Cross' updated toolkit has more robust responses in its analysis, including the information required by the Department of Labor to be considered a "sufficient" response per the April 2, 2021 FAQs.



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**15. Should employer groups begin workin on the analyses or wait for a request from the Department of Labor?**

Because the legal requirement that plans and insurers perform and document comparative analyses of the design and application of NQTLs is separate from the requirement that such analyses be provided to federal agencies upon request, Blue Cross believes that analyses should be prepared whether or not there is a request made by the Department of Labor.

**16. Will Blue Cross charge self-funded clients for assistance in completing?**

Blue Cross will assist self-funded groups in an audit. At this time, Blue Cross is not planning to charge groups for audit support.

*There was a Mental Health Parity webinar held for external clients on May 19. You can listen to a recording of that webinar [here](#). For a copy of the presentation, contact your account manager.*

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## **ID Card Transparency Display**

### **1. When will members start to receive new member ID cards**

Members who have a access to a virtual ID card will see the new information beginning on Jan. 1, 2022. Plastic cards with the additional information required by the CAA will be issued as follows:

- Members whose group has pharmacy benefits with Blue Cross Blue Shield of Michigan will receive their new ID cards between October 2021 through January 2022.
- Members whose group does not have pharmacy benefits with Blue Cross will receive new cards through normal maintenance activity beginning as early as Oct. 1, 2021. Any new card issued, whether due to a member request or benefit changes, on or after Jan. 1, 2021 will have the CAA updates.
- All new members who have cards issued on or after Jan. 1, 2022 will receive a card with the CAA updates.

### **2. What is the effective date for this mandate?**

Cards issued for plan years beginning on or after Jan. 1, 2022.

### **3. What will be new on the virtual member ID cards?**

In-network and out-of-network individual and family deductible, out-of-pocket max, and if applicable, pharmacy deductible and pharmacy out-of-pocket max.

### **4. What will be new on the plastic new member ID card?**

In-network and out-of-network individual and family deductible, out-of-pocket max, and if applicable, pharmacy deductible and pharmacy out-of-pocket max.

### **5. Will members be notified of the changes to their ID Card?**

Yes. We will include information with the card to explain what has changed and why.

### **6. How many new cards will be sent to each contract holder?**

One card for single contracts, two cards for family.

### **7. Can additional cards be requested?**

Yes. Additional cards can be requested through the member portal or customer service.

### **8. Will groups receive multiple sets of cards for the Optum Rx and CAA mandate?**

We are merging the project efforts to reduce the potential of multiple cards being issued. However, if a group adds or removes pharmacy coverage after their cards have already been



issued through the Optum Rx project, then another set of cards will be issued as a result of normal group wide change activity.

**9. Are dual ID cards going to continue to be generated for MA group business?**

Yes, this functionality will remain unchanged.

**10. Will there be a cost associated with reissuing ID cards?**

No, we will not be charging groups for mandatory card reissuance.

**11. Is there any way to postpone the processing of ID cards scheduled to be sent out in the fourth quarter of 2021 until December of 2021?**

No, groups that have pharmacy benefits will require new cards to allow members to access their new pharmacy benefit on Jan. 1, 2022. Medical only groups may also require new cards in the fourth quarter, to the extent they have benefit changes that trigger new cards for the 2022 benefit year. Any card issuance that happens after Jan. 1, 2022 will require the new CAA information.

**12. What happens if a cost share listed on the card is incorrect?**

Call the customer service number on the back of the ID card.

**13. Does the CAA require RX fields on the card regardless of whether pharmacy is carved out?**

No, only If the Blue Cross pharmacy deductible and/or out-of-pocket maximum is separate from the medical deductible and/or out-of-pocket maximum.

**14. What changes will appear for groups with BCN integrated HRA or other HDHP products with flexible spending arrangements? How will deductible information be displayed for BCN groups with integrated HRAs? When a member has a HRA plan, will ID cards show only the member responsibility?**

We are only displaying the totals, the cards will display the accumulation amounts.

**15. What is the value proposition of posting the cost share on the cards and incurring the expense and member confusion with multiple card distributions?**

This is a mandate and not an optional choice made by Blue Cross. A group health plan or health insurance issuer offering group or individual coverage must include the required information on any physical or electronic card issued or after Jan. 1, 2022.

**16. What will happen with Dec. 2021 renewals?**



Renewals will follow standard processes. The timing in which changes are submitted by the group may cause an increase in the chance of multiple card issuance to the members.

**17. When will new groups start getting the new cards?**

Starting in the fourth quarter of 2021, card issuance for 2022 benefit year will begin for groups with both medical and pharmacy coverage.

Card issuance for groups that have medical only coverage will happen when future events that would normally trigger new cards occur. All members who have access to the member portal and their virtual card will be able to access an updated virtual card starting on Jan. 1, 2022.

**18. When do the new plan elections need to be submitted by to ensure only one card is sent to the member?**

There are no dates in which a group can submit changes by to ensure only one card issuance.

**19. For groups that have medical coverage only through Blue Cross, will they get new cards if there are no medical changes? When will the cards come if the medical changes are made effective Jan. 1, 2022?**

For groups with only medical coverage, cards will be issued in 2022 when benefit events would normally trigger card issuance.

All members with access to the member portal and their virtual card will be able to access an updated virtual card starting on Jan. 1, 2022.

**20. If an ASC medical-only plan makes changes on Jan. 1, 2022, will new ID cards be provided at that time?**

If those changes affect the deductible or out-of-pocket maximum amounts, then new cards will be issued.

**21. If there is a combined in and out-of-network deductible, will the ID card reflect this?**

The in-network and out-of-network deductibles will be displayed, the accumulation rules will not be printed.

**22. Will the new ID cards also include the new Rx information?**

Yes.

**23. What will show on the ID card if Blue Cross is not the Rx vendor?**



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No deductible or out-of-pocket max information will appear for pharmacy that is carved out to a pharmacy vendor.

**24. For groups renewing prior to Jan. 1, 2022 can we get them their ID cards so it aligns with their open enrollment?**

The production list for card issuance has been organized by group renewal date.

**25. Will there be a mass issuance in 2022?**

No, starting on Jan. 1, 2022 all cards that are issued will include the CAA updates.

**26. Is it required to issues all new cards with the CAA updates by Jan. 1, 2022?**

No, the plain language of the law does not require card issuance by Jan. 1, 2022 or even by the end of 2022.

***There was a webinar that covered ID cards held for external clients on June 16. You can listen to a recording of that webinar [here](#).***

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# Payer Transparency (not part of the CAA)

## Machine readable files

### **1. How will Blue Cross Blue Shield of Michigan comply with final transparency rules?**

We continue to enhance and refine our transparency tools and believe Blue Cross is well-positioned to improve member experience and accommodate the Federal Transparency mandates by its effective dates. Transparency in coverage requires payers to provide an out-of-pocket cost calculator using several factors to provide a pre-service view of member costs. Additional information will be shared throughout 2021 and into 2022. Blue Cross will provide machine-readable data files that include applicable rates with in-network providers, allowed amounts for items or services provided by out-of-network providers, and historical net prices and negotiated rates for prescription drugs furnished by in-network providers as required by the final ruling (starting July 1, 2022)

### **2. Where can the machine-readable files be found?**

They will be posted on **bcbsm.com**.

### **3. Who will have access to the machine-readable files?**

The files will be available to the public as required by the law.

### **4. How often will the files be updated?**

The files will be updated monthly.

### **5. What will be in the files?**

Blue Cross will publish three JavaScript Object Notation (“JSON”) files which meet the requirement of the regulation. (NOTE: JSON files store simple data structures and objects in JSON format, which is a standard data interchange format. It is primarily used for transmitting data between a web application and a server.)

The data includes:



- All applicable rates (including negotiated rates, underlying fee schedules, or derived amounts) with in-network providers for all covered items and services.
- Billed charges and allowed amounts for covered items and services provided by out-of-network providers.

**6. Do the machine-readable files include out-of-state provider fee schedules and rates or only Michigan-based provider fee schedules and rates?**

Blue Cross will implement its solution to include all providers.

**7. Will Blue Cross file include ASC information on the published files or will Blue Cross offer data to self-funded groups?**

Blue Cross will make data and files available to ASC groups. Location, process to access and monthly timing will be shared with sales, account managers and agents in the second quarter of 2022. ASC groups will retain the ultimate responsibility of complying with machine readable file regulations, including posting requirements.

**8. Is the JSON file searchable?**

As published on our website, no. However, if you download the file there are several tools and ways to consume the data to create a searchable file. One could load the file into notepad and use 'control F' to search. Or one would need to have an interface and/or coding such as jQuery to create a searchable function within the files.

**9. Will Blue Cross provide a user interface that makes the data useful?**

No.

**10. Does the Machine-readable file mandate under the Payer Transparency regulation apply to all groups regardless of group size?**

Yes, the Machine-readable file mandate under the Payer Transparency regulation applies to all groups, regardless of group size, who have members enrolled in commercial products (excluding Medicare, Medicare Advantage, Medicaid, ancillary and short-term limited duration plans).

**11. How are these files providing transparency to customers if members are not able to understand what is in the files?**

We understand that reading .Json files may not be clear and simple. However, to meet the regulatory requirements this is the prescribed format. We believe this mandate provides the



data infrastructure to support upcoming mandates that provide member price transparency tools such as the Price Estimator Tool (also known as Benefit Search Tool) and Advance EOB.

**12. Who does Blue Cross anticipate will be leveraging these files that are required per federal law?**

These files are intended for public consumption. Blue Cross Blue Shield of Michigan cannot predict who will leverage this data once published.

**13. What do agents of small groups have to do for this regulation?**

Plans and issuers have the responsibility for the machine-readable files, but as an agent you should have awareness to assist customers if needed. Blue Cross files posted on BCBSM.com will meet the mandate for fully insured groups. Self-funded groups are required to post their file on a public site. For self-funded groups, Blue Cross will post group specific URLs on the Group Portal. The URL also known as a link will be a static. This static link will open your group's Table of Contents. This means the link will not change month over month, only the content (i.e., the MRF files) will refresh each month.

**14. Will agents be granted access to group portals?**

In order for an agent to be granted access to the group portal, the principal administrator at the group would be required to grant the 'Agent' access to their account on Group Portal.

**15. Will the customer link, for either group funding arrangement, have a warning message regarding file size?**

MRFs will have a disclaimer regarding file size. Self-funded groups can choose to include a disclaimer with the URL on their own public website. Regardless, when a member clicks on the URL the site hosting the MRF's will have a disclaimer.

**16. Who is responsible for posting the public files for fully insured groups?**

Blue Cross and BCN are responsible for making fully insured groups machine-readable files publicly available.

**17. Will these files be easily understood by the average layperson?**

We understand that reading .Json files may not be clear and simple. However, to meet the regulatory requirements this is the prescribed format. We believe this mandate provides the data infrastructure to support upcoming mandates that provide member price transparency tools such as the Price Estimator Tool (also known as Benefit Search Tool) and Advance EOB.

**18. Has Blue Cross updated its agreements to address the requirement in which a written agreement must be in place to relieve a client of liability for these MRF disclosures?**



Self-funded groups can request an amendment to their administrative services contract documenting the support Blue Cross provides related to transparency and CAA compliance. This amendment is specific to self-funded groups only as Blue Cross and BCN are directly responsible for transparency compliance for fully insured groups.

**19. What should a self-funded group do if they do not have an external public website to post the link to?**

If a self-funded groups does not have a public website they should consult with their legal counsel for guidance.

**20. Will Blue plans be coordinating on their approach across the country?**

Yes

**21. Will the link Blue Cross and BCN make available to view these files enable any type of 'confirmation' message to provide assurance to the user all of the data has downloaded to be viewable?**

No

**22. If claims are being utilized to create the information, how is the PHI not revealed?**

The two files that will include provider data, but will not include any member level PHI are depicted below.

1. In-network file: All applicable rates (including negotiated rates, underlying fee schedules, or derived amounts) with in-network providers for all covered items and services. These rates are not derived from claims data.
2. Allowed amount file: Billed charges and allowed amounts for covered items and services provided by out of-network providers. The allowed amount file will be group specific historic data pulled from claims data but will not contain any member's identifying data. The Transparency regulations provided specific guidance to avoid releasing any individually identifiable information by requiring inclusion of only historical payments for providers with more than 20 claims in the first 90 of the preceding 180 days.

**23. What benefit types are included in these files?**

Medical and medical drug benefits are included in these files. If you have benefits carved out of Blue Cross, these benefits will not be included in the MRFs produced by Blue Cross. You will need to contact the entities responsible for administering those benefits for further assistance. Hearing Aid services billable by providers and processed as a medical claim will be included.

**24. Are standalone dental / vision plans included in this regulation?**

No



**25. Can a carrier determine which data elements are to be included or excluded from the files?**

No, the required fields and format are defined within the regulations.

**26. When will the URL for self-funded groups be available?**

Posting dates will be announced mid-to-late June 2022.

**27. Does this requirement apply to retirees?**

The transparency final rule does not apply to retiree-only groups, so their specific data does not need to be included in the files.

**28. What is the amount of claims data included in the applicable files?**

Allowed amount file: Historical payments for providers with more than 20 claims in the first 90 of the preceding 180 days will be included.

For example: July's file will be going back to January (the 180 days) then capturing the first 90 days."

**29. How will the data be refreshed?**

The Table of Contents (ToC) is a static URL, however the machine-readable file links within the ToC will automatically refresh monthly.

**30. What does 'public website mean'?**

Per regulatory requirements as noted on [github.com/CMSgov/price-transparency-guide](https://github.com/CMSgov/price-transparency-guide): All machine-readable files must conform to a non-proprietary, open standards format that is platform independent and made available to the public without restrictions that would impede the re-use of that information. In other words, anyone should be able to access the website.

**31. For self-funded customers that have multiple groups with Blue Cross, is it the same link for each group or are they group specific?**

Table of contents will be at the parent group level.

**32. Will the URL provided provide access to all of the machine-readable files?**

The URL link that will be posted will open to the Table of Contents (TOC). In the TOC there will be links to each file. The files available through the URL will be specific to the self-funded group.

**33. What if a self-funded group is not signed up for the Group Portal?**



Self-funded groups should ensure they are registered for the Group Portal as soon as possible to ensure there are no issues with the registration process and grant access to others, such as IT, if needed. Failure to sign up by June 24, 2022, may increase the risk to publish your groups files on July 1, 2022.

**34. Will the machine-readable files only be accessible for download, or can they be viewable online?**

Download only.

**35. Did the regulations recently change in which self-funded groups can now post links to the data versus posting the actual files?**

Yes, CMS updated requirements as posted on Github.com under version 1.0 that allows for a Table of Contents (TOC). The TOC will include in-network and allowed amount .Json files.

**36. Are the machine-readable files group specific?**

The machine-readable files made publicly available for fully insured groups are not group specific but an aggregate of all data, as per regulations. Because self-funded groups are responsible for posting their own files, that data is group specific where applicable (i.e., when claims data is leveraged to produce the data).

**37. What are the data elements within each file?**

In-network file: rates for items and services of all contracted providers need to be included.

Each listed rate should be associated with the National Provider Identifier (NPI), Tax Identification Number (TIN), and Place of Service Code for each provider. Sample list of items, not limited to:

Reporting entity name

Entity type

Plan name

Plan ID type

Plan ID

Plan market type

Date it was last updated

The negotiation arraignment with Blue Cross for said provider/facility



Name

Description

Billing code type, version and code

The rate for said code

The provider groups NPI, TIN and type of TIN

Out-of-network allowed amount files: only historical payments for providers with more than 20 claims in the first 90 of the preceding 180 days need to be included.

For example: July's file will be going back to January (the 180 days) then capturing the first 90 days, so the data will be from January, February and March on the July file.

### **38. What is the three step process that self-funded groups should follow to access their files?**

The 3-step process for groups to prepare for July 1st effective date is:

- Step 1: Group and/or TPA ensures they have access or register for the Blue Cross' Group Portal
- Step 2: Once we have sent notification that the portal has been loaded with the MRF URLs, the group will sign into group portal and copy their unique URL
- Step 3: The group will take their copied URL and post on their public site of their choosing

Self-funded groups are required to post file on a public site. For self-funded groups, Blue Cross will post group specific URLs on the Group Portal. The URL also known as a link will be a static. This static link will open your group's Table of Contents. This means the link will not change month over month, only the content (i.e. the MRF files) will refresh each month.

### **39. Are grandfathered plans in or out of scope for machine-readable files?**

Grandfathered plans are out-of-scope for machine-readable files.

### **40. What does 'machine-readable file' mean?**

Machine-readable data is data (or metadata) in a format that can be easily processed by a computer. There are two types: human-readable data that is marked up so that it can also be read by machines (e.g. microformats, RDFa, HTML) or data file formats intended principally for processing by machines (RDF, XML, JSON).





Per regulatory requirements as noted on [github.com/CMSgov/price-transparency-guide](https://github.com/CMSgov/price-transparency-guide): Content type should be non-proprietary, open format. CMS noted .Json, XML and YAML as formats that will meet the needs for Transparency in Coverage. Blue Cross is using .Json format.

**41. Will links be available under the agent portal ebookshelf?**

The links will be housed under the same tab as e-bookshelf.

**42. Where can I locate an example of the data I will see when reviewing the files from the link?**

Examples were given in the May 12, 2022 webinar. The webinar link is offered in the May Group Customer Digest and is offered in the Machine-readable files FAQ.

**43. Will there be only one link by group, or will that vary by type of plan?**

This will vary by group, depending on their group structure and plan selection. For the allowed amount it will also depend on the group claim experience within the 90 days of data captured.

**44. Do I contact my account manager if the URL does not appear in time for 7/1?**

Yes

**45. Is the file size out of Blue Cross' control? Are there plans to decrease its size to improve the ability for people to access?**

Yes, the files and their requirements are prescribed by CMS. If CMS develops a method for decreasing file size groups will be advised.

**46. If a self-funded client does not have a public website, would Blue Cross post the URL on their behalf on their site?**

No, the self-funded group is responsible for publicly posting the link.

**47. Does BCN self-funded groups have a differing three step process to access the link?**

No.

**48. Is there a required communication to employees?**

No.

**49. Will Blue Cross support the next/future phases of the transparency requirements for self-funded groups?**

June 3, 2022



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Blue Cross will continue efforts to ensure reasonable solutions are developed.

*There was a Payer Transparency webinar held for external clients on May 12. You can listen to a recording of that webinar [here](#). For a copy of the presentation, contact your account manager.*

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## Reporting on prescription drug and health care spending

On November 17, 2021 the federal departments issued a joint [interim final rule](#) with significant new detail on the reporting requirements laid out in Section 204 of the Consolidated Appropriations Act for reporting on prescription drug and health care spending to HHS.

On November 23, 2021, CMS issued a draft [information collection package](#) with more detailed reporting requirements for responsible entities.

### 1. Who is required to submit the report?

Required to Submit	Not Required to Submit
<ul style="list-style-type: none"> <li>• Health insurance issuers offering group and individual market coverage</li> <li>• Self-funded group health plans, including:                             <ul style="list-style-type: none"> <li>○ Non-federal governmental plans</li> <li>○ Church plans that are subject to the Internal Revenue Code</li> <li>○ Federal Employees Health Benefit (FEHB) plans</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Account-based plans, such as health reimbursement arrangements</li> <li>• Excepted benefits including but not limited to:                             <ul style="list-style-type: none"> <li>○ Short-term limited-duration insurance</li> <li>○ Hospital or other fixed indemnity insurance</li> <li>○ Disease-specific insurance</li> </ul> </li> <li>• Medicare Advantage and Part D plans</li> <li>• Medicaid plans</li> <li>• State Children’s Health Insurance Program (CHIP) plans</li> </ul>

### 2. When is the deadline?

The deadline for 2020 and 2021 reports is December 27, 2022. The deadline for



subsequent reports is June 1<sup>st</sup> of the calendar year immediately following the year being reported.

### **3. What information is required?**

The CAA requires insurance companies and employer sponsored health plans to submit information about:

- Spending on prescription drugs and health care services
- 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

### **4. What files are required?**

The plan list files are (P stands for Plan):

- P1. Individual and student market plan list
- P2. Group health plan list
- P3. FEHB plan list

The data files are (D stands for Data):

- D1. Premium and Life-Years
- D2. Spending by Category
- D3. Top 50 Most Frequent Brand Drugs
- D4. Top 50 Most Costly Drugs
- D5. Top 50 Drugs by Spending Increase
- D6. Rx Totals
- D7. Rx Rebates by Therapeutic Class
- D8. Rx Rebates for the Top 25 Drugs

### **5. What information will be publicly released?**

The federal departments intend to publish findings about prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs.



You will be able to download the report from the websites of the Department of Labor or the Department of the Treasury.

The data will be available in an aggregated format no later than 18 months after the date the first report is required and biannually thereafter. The law requires the agencies to aggregate the data in such a way that no drug or plan specific information will be made public.

**6. Will support be provided to self-funded plans?**

Blue Cross is working to ensure self-funded plans have access to the necessary medical data and pharmacy data (if Blue Cross administers pharmacy benefits) required to be reported to the federal government.

**7. When will additional guidance be published?**

The federal government has not given a date yet on when additional guidance will be released. Blue Cross will provide an update if additional guidance is made available.

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## Surprise Billing

### 1. What is balance billing and surprise billing?

We all know that when a member sees a doctor or other health care providers, they may owe certain out-of-pocket costs, such as a copayment, coinsurance or deductible that are part of their health plan.

However, when members choose to go to providers who don't participate with their health plan, there could be other costs as well. These non-participating providers don't have a signed contract with a member's health plan. As a result, the providers can charge the member the difference between what the health plan pays, and the provider's full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward the member's annual out-of-pocket limit.

Surprise billing is a type of balance billing that is unexpected because the member can't control who is involved in their care. This could happen when there is an emergency, or the member schedules a visit at a participating facility but are unexpectedly treated by a nonparticipating provider.

### 2. How does the federal No Surprises Act protect members from surprise billing (unexpected balance billing)?

The federal No Surprises Act, which goes into effect on Jan. 1, 2022 nationwide, protects members from surprise billing in the following scenarios:

#### **Emergency services**

If a member has an emergency medical condition and gets emergency services from a nonparticipating provider or facility, the most the provider or facility may bill them is their plan's in-network, out-of-pocket amount (such as copayments, coinsurance, and deductibles). The member can't receive a surprise bill for these emergency services. This includes services the member may get after they're in stable condition unless they give written consent and give up their protections under the No Surprises Act for these post-stabilization services.



Depending on their plan, the member may have additional protections under Michigan law if they receive post-stabilization services from a nonparticipating provider when they are in a participating facility. If their plan is governed by Michigan law, those providers cannot bill them more than the plan's in-network, out-of-pocket amount even if they receive written consent.

### **Certain emergency and non-emergency services at a participating hospital or ambulatory surgical center**

When a member gets services at a participating hospital or ambulatory surgical center, certain providers who work there may be nonparticipating. In these cases, the most those providers may bill is the member's in-network out-of-pocket amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers can't bill a member more than that amount and may not ask them to give up their protections under the No Surprises Act.

If the member gets other services at these participating facilities, nonparticipating providers can't bill them more than the in-network, out-of-pocket amount unless the member gives written consent to give up their protections.

### **3. When surprise billing isn't allowed, what protections does the member have?**

The member is only responsible for paying their share of the cost (such as copayments, coinsurance and deductibles that they would pay if the provider or facility was in network). Their health plan will pay nonparticipating providers and facilities directly. The health plan generally must:

- Cover emergency services without requiring the member to get approval for services in advance (prior authorization).
- Cover emergency services by nonparticipating providers.
- Base what the member owes the provider or facility (out-of-pocket costs) on what it would pay an in-network provider or facility and show that amount in their explanation of benefits.
- Count any amount the member pays for emergency services or services rendered by nonparticipating providers in the circumstances outlined above toward their deductible and out-of-pocket limit.



**4. What group customers are affected by the federal law?**

Beginning Jan. 1, 2022, the federal law will be effective for self-funded ERISA\* plans, grandfathered plans and federal health plans.

For fully insured plans and self-funded state or local government plans, the state law applies for professional provider payment rates and arbitration procedures, but the federal surprise billing law will govern otherwise.

**5. Does the surprise billing law eliminate the practice of balance billing?**

No, certain out-of-network providers can balance bill members for non-emergency services when the provider gives the required advance written notice and an estimate of the cost of care.

**6. What should a member do if they receive a surprise bill after Jan. 1?**

Anyone who believes they received a surprise bill after Jan. 1 should call the customer service phone number located on the back of their ID card.

**7. What is out of scope for the federal surprise billing law?**

Medicare, Medicare Supplemental/Medigap, Medicare Advantage, Medicaid, retiree-only plans, ground ambulance, stand-alone dental, stand-alone vision, excepted benefits (e.g., HRA's and short-term limited duration plans).

**8. How does this apply to self-funded groups that have custom (non-standard) arrangements?**

Claims will be paid according to the surprise billing laws, when appropriate, even for those groups with custom (non-standard) arrangements for payment of services rendered by nonparticipating providers (e.g., pay up-to-charge or a percent-of-charge).





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**9. Why is Blue Cross removing the benefit design that requires an individual to seek care within 72 hours of the onset of an emergency?**

Some groups have a benefit design requiring an individual to seek care within 72 hours of the onset of an emergency for such services to be covered. This limitation is no longer appropriate under the definition of emergency in the No Surprises Act, therefore, we are removing it from our claims processing system.

**10. Has the language been finalized for the No Surprises Billing notice and will Blue Cross put it on their website?**

Yes the language has been finalized and Blue Cross is working to have the model language posted on **bcbsm.com** starting Jan. 1, 2022.

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