Transparency in Coverage Regulation and Consolidated Appropriations Act

External FAQs for HealthLink

For purposes of this document, TPA refers to both a third-party administrator and a self-administered plan.

Last Update: February 2024 (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

HealthLink supports its clients in their efforts to 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 and advance explanation of benefits – 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. CMS has indicated it will issue additional guidance on this provision and how it relates to the CAA price comparison requirements. 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 is pending technical requirements and an implementation timeline, which the Tri-Agencies will provide in future guidance. The purpose of the rule is to provide transparency that federal regulators believe will promote consumer choice and competition among providers.In instances where rates cannot be disclosed in specified amounts (e.g., dollar), the Tri-Agencies will use a case-by-case approach to determine whether enforcement is appropriate.

What areas will HealthLink take responsibility for and make updates to be in compliance?
HealthLink has developed Machine Readable Files for in-network rates only. The file is available on HealthLink.com for direct access or the TPA can provide a link for public website.

How will carve-out situations be handled?
In situations where a group has a vendor other than HealthLink for certain services (e.g., Pharmacy), HealthLink's pricing and rate information will not apply. Therefore, the group may need to make additional arrangements.

What areas does HealthLink 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?
HealthLink has provided Machine Readable Files for in-network rates only to be used as a resource but will defer to the TPA for the transparency tool.

Will you support the client's communication to their members on these changes and new resources?
We do anticipate communicating with TPAs, brokers and clients as to our implementation activities for these laws. Clients may use these communications to develop communications for their members.

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.
HealthLink does not currently use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are issued.

What plans are subject to the Transparency Rule?
According to the Regulation, the Transparency Rule applies to health insurance issuers in the group and individual markets. It also applies to group health plans, including group health plans that are fully-insured, as well as those that are self-funded. It also applies to Qualified Health Plan issuers and the Federal Employees Health Benefits Program.

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 HealthLink.com. Clients can link to those files; but due to the size of the files, we are not providing the data directly to our clients for them to put on their websites. HealthLink is only 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.

We will post the data attributable to in-network HealthLink rates only, since that is based on our contracted fee schedules.

Will you build and manage the publicly accessible website with all required machine-readable files on behalf of your employer clients?
The machine-readable files for the data we administer and maintain are made accessible through healthlink.com. The data is posted in compliance with the requirements. Clients can link to those files; but due to the size of the files, we are not providing the data directly to our clients for them to put on their websites. HealthLink is only publishing the data it maintains, so if a plan uses another vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

What are machine-readable files intended to be used for?
According to the preamble to the Transparency in Coverage rule, the purpose of the files is to allow "the public to have access to health coverage information that can be used to understand health care pricing and potentially dampen the rise in health care spending." The government expects private entities to create apps or websites to enable consumers to view and compare this rate information. Once again, the files are "machine readable," so consumers must rely on someone with a computer program and system capability to digest the files and render them viewable.

How often will the machine-readable files be updated?
The regulation outlines that the files are required to be updated monthly and HealthLink is providing on the last day of each month.

Will there be a cost for compliance with the machine-readable file requirement?
There will be no additional charge for this specifically. However, the new regulations may be taken into consideration when determining our administrative fees.

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

Will the publicly available files be accessed through the current participant portal or be located in a new portal? Can plan sponsors link to the files?
These files are accessible through healthlink.com, a publicly available website. Plan sponsors may link to those files as desired.

How will client-specific machine-readable files be accessed on healthlink.com?
Beginning July 1, 2022, HealthLink has been publishing the machine-readable files for in-network rates we maintain. These files are published on HealthLink.com and can be accessed using this link: (https://www.healthlink.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 allows you to search for files using an Employer Identification Number (EIN).

What is an 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.

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

May a group health plan that does not have its own website satisfy the requirements of the TIC Final Rules with respect to posting the Allowed Amount file and the In-network Rate file on a public website of the plan, if the plan's service provider posts the Allowed Amount file and the In-network rate file on its public website on behalf of the group health plan?
Per CMS FAQ #37 published on 6/17/22 (https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification), if a group health plan does not have a public website, the plan may satisfy the requirements for posting the Allowed Amount file and the In-Network file by entering into a written agreement under which a service provider (such as a TPA) posts the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan. However, if a plan enters into an agreement under which a service provider agrees to post the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan, and the service provider fails to do so, the plan violates these disclosure requirements. The Departments intend to follow up with the issuance of formal guidance soon.

How do I know which file to pick for my product?
For the files posted by HealthLink, the JSON File naming convention will reflect the brand (HealthLink, UniCare or ANTH) and product name (e.g., PPO, HM2).

Please describe how HealthLink will respond to questions regarding the files.
Please contact your HealthLink Sales and Account Management team for any specific questions regarding the files. Your Account Manager will ensure that the question is routed to the appropriate team for response.

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, the in-network machine-readable files only are made available on healthlink.com. Out-of-network and prescription drug negotiated rates files are not provided.

How do you handle rates for providers that have been terminated?
Terminated providers will be dropped each month and new provider records will be added. Changes will be reflected in the files the month after the termination.

Will the machine-readable files be archived and how will the archived files be accessed?
The files will be archived according to the legal retention period of 10 years. If a regulator requests information associated with a file, please reach out to us and we will work with the regulator to get the information they need. The client also has the ability to download and archive.

Cost Transparency Tool

The Transparency in Coverage 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 expanded those tools to cover all items and services effective 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.

We expect that TPAs can access the machine-readable files in order to get pricing to produce their own cost- transparency tool.

Will HealthLink make the tool available to plan participants?
No, HealthLink anticipates partnering with the TPA to ensure they have the information required for the member inquiry.

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. 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 in future rulemaking.

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

What types of plans are excluded from the scope of the CAA?

- Short-Term Limited Duration plans
- Government Plans (e.g., Medicare, Medicaid)
- Retiree Only Plans
- Account Based Plans (e.g., HRA, HSA) *Note: The underlying health plan (e.g., High Deductible Health Plan (HDHP) is in the scope of the CAA.*
- Excepted Benefits (e.g., Standalone Dental or Vision)

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

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.

Will there be a cost for compliance with the CAA?
At this time, there will be no additional charge for compliance changes.

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 health care 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 expanded those tools to cover all items and services effective 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 separate 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 are delayed until January 1, 2023, to align with the Transparency in Coverage regulation effective dates. The Tri-Agencies said they would 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.

Will you support the plan's communication to members on these changes and new resources?
We do anticipate communicating with our clients/TPAs as to our implementation activities for these laws. Such communications are available on HealthLink.com under Employers and TPAs pages.

Are any subcontractors or third parties 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?
HealthLink does not use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are finalized.

Price Comparison Tool

The CAA 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 Transparency in Pricing regulation with the Price Comparison tool requirements of the CAA. Additional rulemaking guidance is anticipated.

For more information, please see the Cost Transparency Tool section above.

Provider Directory

The CAA requires plans to establish a verification process to confirm provider directory information at least every 90 days, including removing providers or facilities who are non-responsive. 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. These regulations or other regulatory guidance has not yet been issued. However, 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.

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

Will directory be available electronically and/or printed?
Yes, this is current state.

Will you accept responsibility for directory inaccuracies resulting in added plan cost?
The indemnification provision in the HealthLink payor agreement may apply.

Will you comply with the provider directory requirements on behalf of your groups?
Much of the important detail of CAA provisions will be determined by future regulatory guidance. .

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 TPAs of the update?
No.

Will the versions be dated, so TPAs 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 a plan sponsor 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 Consolidated Appropriations Act of 2021 (commonly referred to as the Consolidated Appropriations Act (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 Mental Health/Substance Use Disorder (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 Act (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 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 the amounts to pay providers is determined, utilization management, creation of medical policies and case management. The law requires that behavioral health conditions are treated no less favorably than medical conditions.

Who does this law apply to?

The law applies to all types of group plans, including self-funded clients.

How will HealthLink comply with this law?

HealthLink has created NQTL analysis for its applicable standard processes and procedures (e.g., Credentialing, Medical Policy, Provider Reimbursement, 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 the plan utilizes HealthLink's standard policies and procedures. HealthLink has used the U.S. Department of Labor (DOL) self-compliance tool to analyze its compliance with the NQTL requirements.

Does the HealthLink NQTL analysis apply to all plans subject to the law, whether fully insured or self- funded groups?
HealthLink does not have any fully-insured business. To the extent a self-funded group utilizes HealthLink's standard processes and procedures for the administration of the Plan (e.g., credentialing), HealthLink's NQTL summaries will be applicable to any inquiries. However, if a group deviates from HealthLink's standard procedures (e.g., removes services from the prior authorization list or choose to use another vendor for its utilization management), then NQTL analysis would be the responsibility of the group or its other vendor(s).

Will HealthLink provide required NQTL documentation?
HealthLink 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, HealthLink will not provide any analysis for NQTLs that are within the group's responsibility (e.g., benefit exclusions, etc.).

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 and may be impacted by various court cases. The information provided below incorporates the regulations that were issued on July 1, 2021, and September 30, 2021. On August 19, 2022, the Tri-Agencies issued "Requirements for Surprise Billing: Final Rules." We are expecting another final rule on this provision. The Tri-Agencies have also indicated enforcement discretion until May 1, 2024 for good faith, reasonable interpretation recalculations of the Qualifying Payment Amount ("QPA") to occur. They will continue to evaluate extension of the QPA safe harbor as appropriate.

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 HealthLink determine the Qualifying Payment Amount?
No, HealthLink will not determine the QPA. The TPA or its vendor/partner will determine member cost-sharing.

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 HealthLink offer services to support this?
For HealthLink, the TPA is responsible for paying the provider directly.

Will HealthLink handle the IDR process for the group?
HealthLink will not handle the IDR process. The plan sponsor will be responsible for the IDR process.

What can the client expect in regard to IDR fees and expenses?

CMS issued the following guidance on the ranges of fees that can be expected for Independent Dispute Resolution for calendar year 2023 and 2024:

Fee Type	**Applies[i] for disputes initiated between: 1/1/23- 8/2/23**	**Applies [ii] for disputes initiated between: 8/3/23-1/21/24**	**Applies[iii] for disputes initiated on or after 1/22/24**
Administrative fee	**$350**	**$50**	**$115**
IDRE Fee	Single dispute: **$200-$700** Batched dispute: **$268-$298**	Single dispute: **$200-$700** Batched dispute: **$268-$298**	Single dispute: **$200-$840** Batched dispute: **$268-$1,173**
IDRE Fee Tier BATCHING- based on the number of line items	2-20 lines:100%* 21-50 lines: 110% 51-80 lines: 120% >80 lines: 130%	2-20 lines: 100%* 21-50 lines: 110% 51-80 lines: 120% >80 lines: 130%	Fixed fee range: **$75-$250**, *starting with the 26th line item*

**The percentage applies to the approved batched determination fee and increases with the amount of line items included per batch.*

[1] IDR Administrative Fee Guidance 2023 FAQs
[1] October 2022 Fee Guidance Calendar Year 2023
[1] IDR Process Fees Final Rule_12.21.23

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

ID Card Requirements

The CAA requires health plans to provide information on ID cards 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. These regulations or other regulatory guidance has not yet been issued. However, Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

ID cards are the responsibility of the group health plan or their TPA.

Prohibition on Gag Clauses

The CAA Gag Clause provision prohibits group health plans and health insurance issuers offering group health insurance coverage from entering into an agreement between a plan or issuer and a healthcare provider, network or association of providers, third-party administrator, or another service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from disclosing or accessing certain price and quality information.

In addition, group health plans and issuers are required annually to submit an attestation to confirm compliance with the prohibition on gag clauses.

We are providing clients and TPAs with the following confirmation of compliance, that will allow you to complete the attestation on the CMS HIOS portal:

> *HealthLink represents that the participation agreements with the healthcare providers in its networks are consistent with the requirements set forth in Section 201 of the Consolidated Appropriations Act, 2021.*

This attestation statement applies only to the business and information that we administer and maintain.

Clients need to complete the required attestation by the December 31 each year. Please reference the following CMS link for submission instructions on how to complete this attestation: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/gag-clause-prohibition-compliance

HealthLink's standard provider contract language does not contain a "gag clause". To the extent that a negotiated provider contract may contain a "gag clause", such clause ceased to apply as of the law's effective date.

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.

Describe how you will implement the requirement to allow continuation of care for individuals when their health care provider is terminated from the Network, under ERISA Section 718 and PHSA Section 2799A-3.

We anticipate that much of this requirement will be coordinated by the TPA, however we recognize that HealthLink will need to work with our TPA partners to ensure notification when a provider has left the network. We currently have a process for notifying TPAs, if desired, of providers leaving the network and will continue to work with TPAs to expand that notification process.

Pharmacy and Other Health Reporting

The Consolidated Appropriations Act (CAA) requires health insurers offering group or individual health coverage and self-funded 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
- Narrative Response

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of the pharmacy and other health 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 that were subsequently updated. Critical reporting detail continues to be provided.

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 Group Health Plan or TPA may submit the Spending by Category reporting, while the PBM submits pharmacy related reports such as the Top 50 Most Costly Drugs report.

Who is required to complete the reporting for HealthLink business?
Please consult with your TPA and any carve-out vendors you work with for guidance regarding the reporting submission.

Air Ambulance Reporting
The Consolidated Appropriations Act requires group health plans and health insurance issuers to report information about claims data for air ambulance services and such other information regarding air ambulance services as specified by the Secretary of HHS.

The CAA also requires providers of air ambulance services to submit information regarding air ambulance services, including air ambulance providers' transportation and medical costs, information on each provider's bases and aircraft, the number of air ambulance transports by payor and other information about transports, data on claims denials, and other information specified by the Secretary of HHS.

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.

When is the Air Ambulance Reporting due?
According to the proposed regulation, the reporting is required for two years only. Reporting for 2022 data will be due March 31, 2023, and reporting for 2023 data will be due March 31, 2024, however at this time there is no final regulation providing the needed details for submission. It is anticipated that this date will be moved.

How will the reporting be used?
The Secretary of HHS, in consultation with the Secretary of Transportation, will issue a comprehensive public report summarizing the data and providing an assessment of the state and certain aspects and characteristics of the air ambulance market.

Will HealthLink submit the reporting on behalf of clients?
No. Please contact your TPA for information regarding the submission of Air Ambulance reporting.

HealthLink®, Inc., is an Illinois corporation. HealthLink, Inc. is an organizer of independently contracted provider networks, which it makes available by contract to a variety of payors of health benefits, including insurers, third party administrators or employers. HealthLink has no control or right of control over the professional, medical judgment of contracted providers, and is not liable for any acts or failures to act, by contracted providers. HealthLink, Inc. is not an insurance company and has no liability for benefits under benefit plans offered or administered by payors. HealthLink® is a registered trademark of HealthLink, Inc.