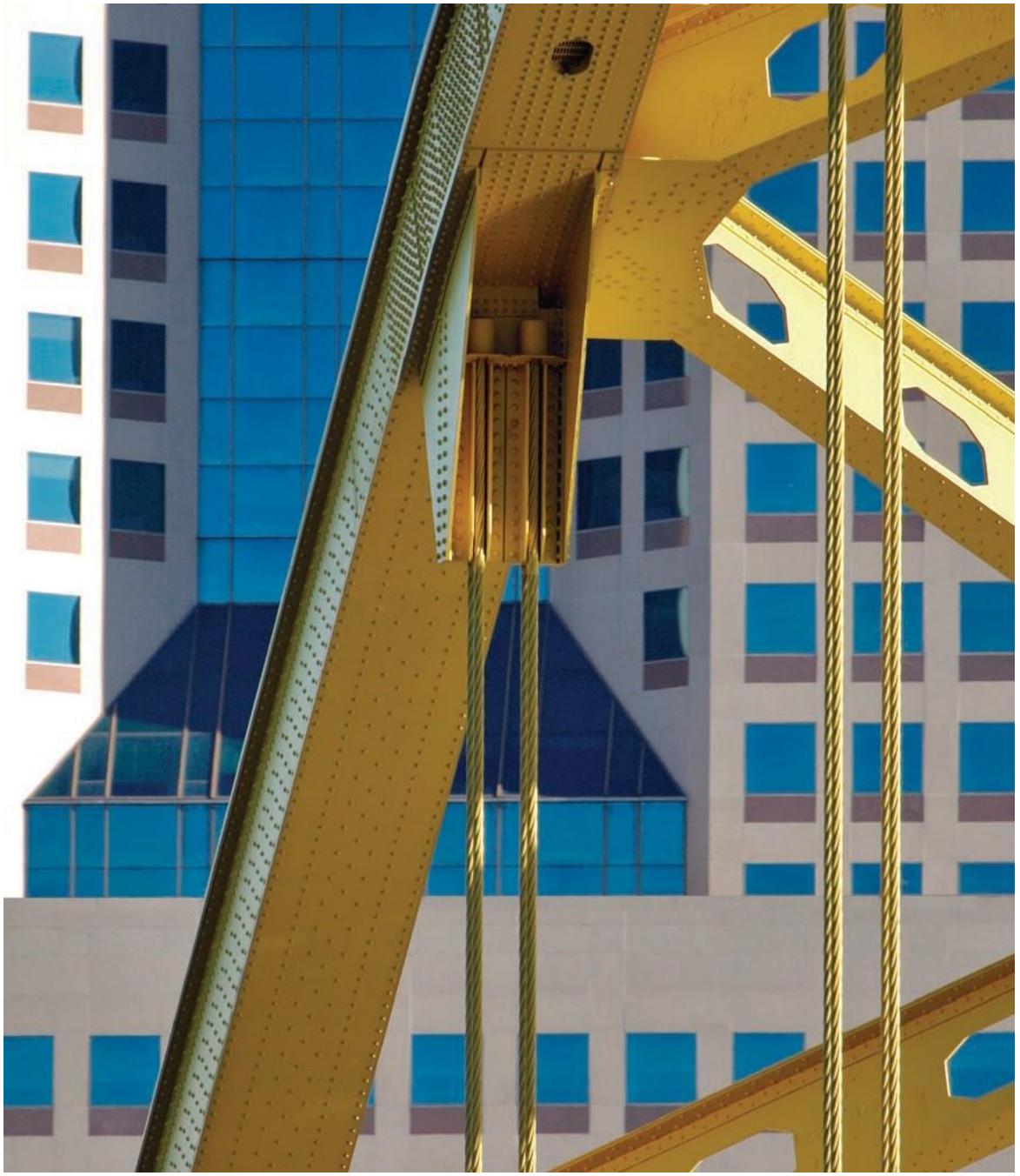
Transparency Mandates

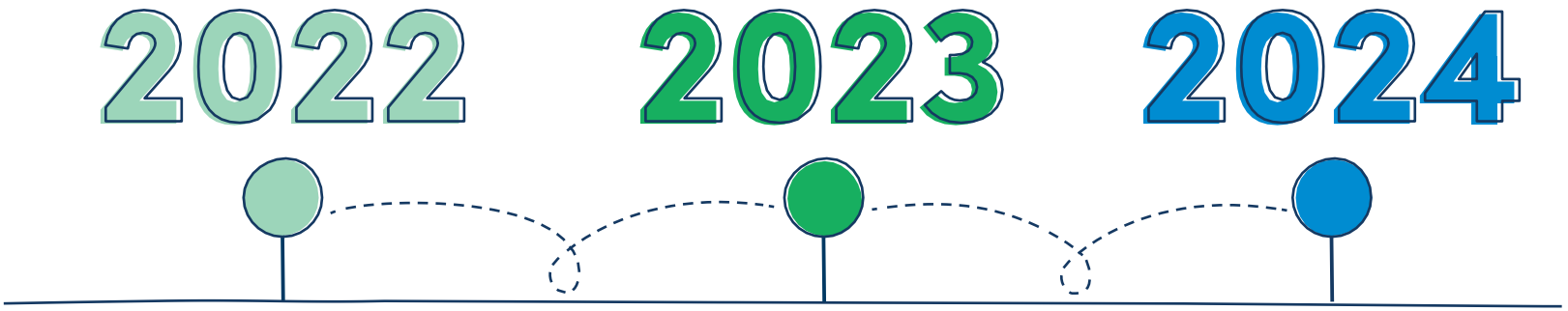
TRANSPARENCY MANDATES

Our 20 years of experience with consumer tools tell us that most people want clear information about their own out-of-pocket costs, the quality of care provided by their doctors and whether their doctors, hospitals, and other clinicians are in their network.

We strongly support greater transparency and are committed to providing members with the health care quality and price information they need to make the best decisions for themselves and their families.



Transparency Overview



2022

- In-network and out-of-network deductibles and out- of-pocket maximum limitations on ID cards
- Publish electronic files on negotiated rates and payments for medical and pharmacy*
- Provide Advance EOB's (deferred), cost estimator tool and verifiable current provider directory
- Additional benefit payment requirements (i.e. Surprise billing, continuity of care, etc.)

2023

- Cost calculator will be made available with personalized INN and OON member cost share for 500 shoppable services

2024

- Cost calculator will be made available for all covered items and services

EMPLOYER RESPONSIBILITY

- Communicate to employees about new ID cards
- Educate employees on cost estimator tool
- Submit a request to the health plan for Mental Health Parity NQTL analysis if requested by state and/or federal regulators
- If needed, update benefits, booklets or Summary Plan Descriptions
- Resolution process
- If pharmacy is carved out, work with PBM to comply
- Educate employees on new,additional EOB

**Carved out vendors will not be supported by the health plan*

Machine Readable Files

Transparency in Coverage Rule

Health Plan Responsibility

DESCRIPTION

Health plans must make publicly available three machine-readable files in a standardized format updated monthly.

- Health Plan will generate In-Network, Out-Of-Network and Prescription Drug files
- Files will be hosted on a public website
- No cost will be associated to hosting files

Effective Date: January 1, 2022 | **Enforcement Date:** July 1, 2022 (In-network Drug file deferred)

IN-NETWORK NEGOTIATED RATES

OUT-OF-NETWORK ALLOWED AMOUNTS

IN-NETWORK PRESCRIPTION DRUGS

Machine-Readable Files

HOW TO LOCATE FILES:

Navigate to website: mrfdata.hmhs.com

Please note that this link will be activated July 1, 2022

Search “Plan Type” with Employer Identification Number (EIN) within the Table of Contents

Click on the URL for “In-Network” or “Allowed Amount”

EXAMPLE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Price Comparison Tools

Transparency in Coverage Rule

Health Plan Responsibility

DESCRIPTION

Health plans must make available personalized cost information, the underlying negotiated rates for all covered items and services and out-of-network (OON) allowed amounts through a self-service tool and in paper form upon request.

- Will include the 500 shoppable services
- Price comparison tool will be available on member portal and include personalized cost information
- Telephonic requests will be accommodated
- No cost will be associated to hosting files

Effective Date: January 1, 2023 | **Enforcement Date:** January 1, 2023

Employer Responsibility — Educate employees about self-service tools

JANUARY 1, 2023

An initial list of 500 shoppable services as determined by the Departments

JANUARY 1, 2024

The remainder of all items and services

Provider Directory

Consolidated Appropriations Act

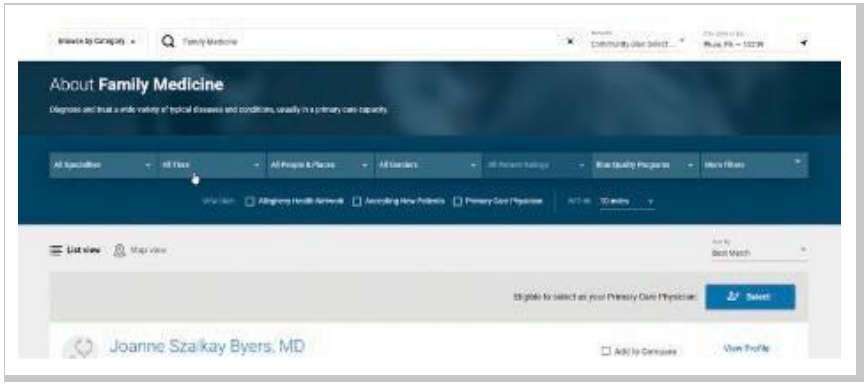
Health Plan Responsibility

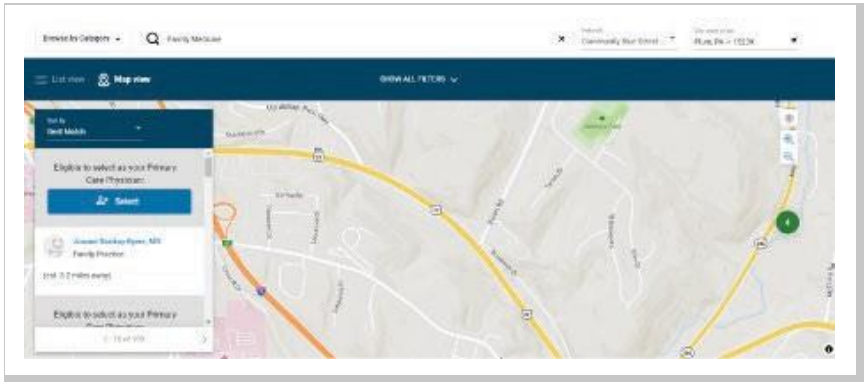
DESCRIPTION

Requires group health plans and issuers to establish a verification process to confirm directory information at least every 90 days. Changes to provider data must be reflected within two (2) business days. Member network questions must be responded to within one (1) business day, incorrect network status could result in member paying in-network cost share amounts.

- Will continue to host the online provider directory and update within 48 hours of receipt of updates from providers.
- Providers will verify provider directory information at least every 90 days or be removed from the provider directory.
- Health Plan will address member network questions.

Effective Date: January 1, 2022 | **Enforcement Date:** January 1, 2022





ID Cards

Consolidated Appropriations Act

Health Plan Responsibility

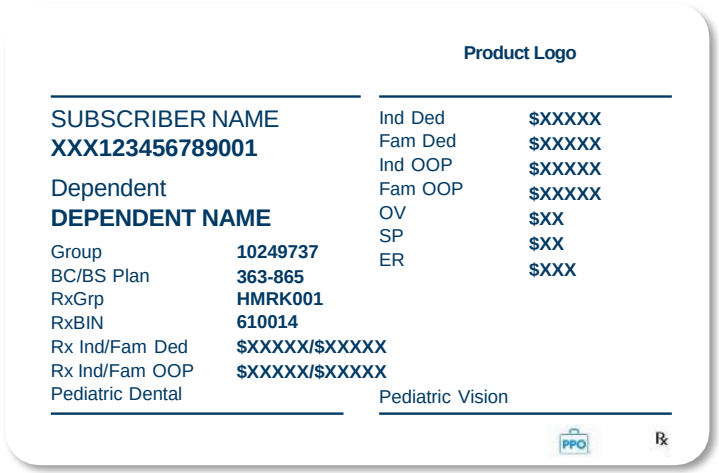
DESCRIPTION

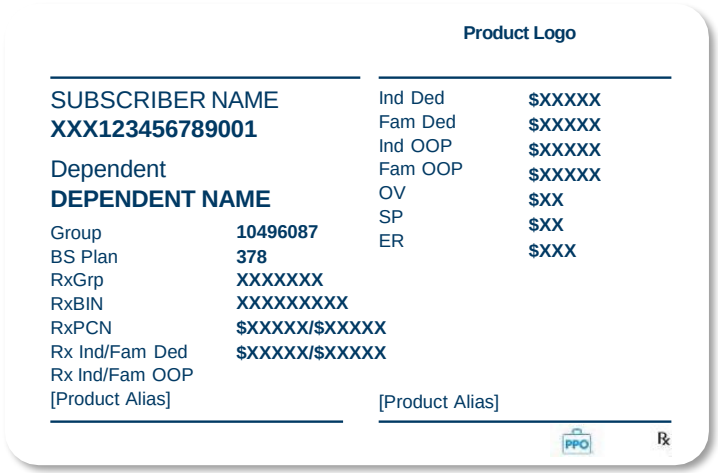
Requires plans and issuers to include in clear writing, on any physical or electronic plan or insurance identification (ID) card issued to participants, beneficiaries, or enrollees, any applicable deductibles, any applicable out-of-pocket maximum limitations, and a telephone number and website address for individuals to seek consumer assistance.

- All members will receive new ID Cards in 2022 upon client renewal, or upon the anniversary of the client's Plan Year, whichever comes first.
- New card formats that display the individual and family program deductible and OOP Maximum/Limit for all plans subject to NSA.

Effective Date: January 1, 2022 | **Enforcement Date:** January 1, 2022

Employer Responsibility — Educate employees about new ID card





Mental Health Parity

Consolidated Appropriations Act

Health Plan Responsibility

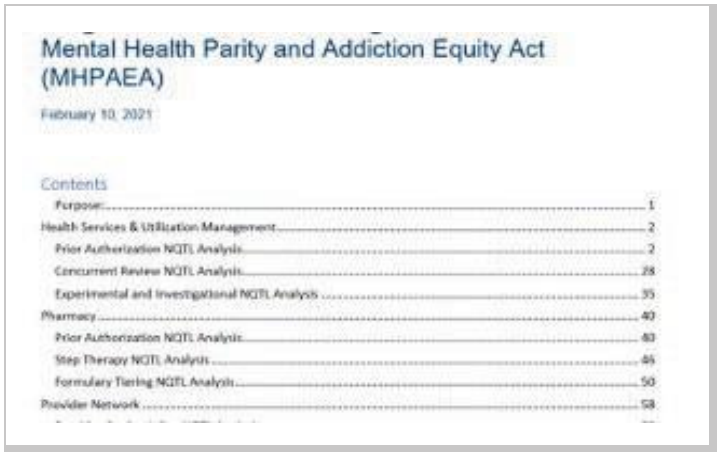
DESCRIPTION

Requires group and individual health plans to perform, document, and provide upon request comparative analyses of the design and application of Non- Quantitative Treatment Limits (NQTL).

- Health Plan will provide NQTL analyses by plan.
- Client will not be charged for these analyses when requested by state and/or federal regulators.

Effective Date: February 10, 2021 | **Enforcement Date:** February 10, 2021

Employer Responsibility — Submit request from regulators to client manager


Mental Health Parity and Addiction Equity Act (MHPAEA)

February 10, 2021

Contents


Health Services & Utilization Management

NQTL: Prior Authorization

Surprise Billing

Consolidated Appropriations Act

DESCRIPTION

Establishes requirements to protect patients from surprise medical bills.

- Provides for patients to be responsible for only in-network cost-sharing amounts for emergency care services received in an Emergency Room, including those received during the stabilization period, services rendered by out-of-network providers when a member is a patient at a network hospital and air ambulance claims.
- Providers may not balance bill patients for services subject to No Surprise Bill protections
- Includes an arbitration process for dispute resolution

Effective Date: January 1, 2022 | **Enforcement Date:** January 1, 2022

Health Plan Responsibility

- Develop new pricing for OON providers rendering services subject to NSA protections
- Align Network and Out-of-Network benefits for NSA claims
- Update claim system to identify NSA claims and point to correct pricing and benefits
- Build negotiation and IDR capabilities in case providers dispute initial payment.

Employer Responsibility — Make benefit changes or update benefit booklets or SPDs

Continuity of Care

Consolidated Appropriations Act

DESCRIPTION

These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status.

- When there is a change in the provider network, certain members undergoing continuous care may continue to receive services from the now out-of-network provider for up to 90 days under the terms and conditions that were applicable prior to the change to allow for a transition of care to an in-network provider.
- If the patient chooses to continue with their current provider, the provider must accept the previous in-network payment and cost-sharing rates for those 90 days from the date of notification to the member or until the treatment is concluded, whichever is sooner.

Effective Date: January 1, 2022 | **Enforcement Date:** January 1, 2022

Health Plan Responsibility

- Expand current Continuity of Care process to broader population
- New notifications of Continuity of Care rights to certain members when providers are terminated

Air Ambulance Reporting

Consolidated Appropriations Act

Health Plan Responsibility

DESCRIPTION

Patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (including attributing the bill to the in-network deductible). Air ambulances are barred from sending patients balance bills for more than the in-network cost-sharing amount.

- Reporting of claims experience to tri-agencies as required.

Effective Date: January 1, 2022 | **Enforcement Date:** January 1, 2022

Health plans and air ambulance providers can negotiate discounted rates for OON services

Requires air ambulance providers to submit cost data → **Requires health plans to submit claims data** → **HHS and Transportation Secretaries**

Remove Gag Clauses

Consolidated Appropriations Act

Health Plan Responsibility

DESCRIPTION

Bans gag clauses in contracts between providers and health plans that prevent enrollees, plan sponsors or referring providers from seeing provider-specific cost and quality data.

- Highmark provider contracts do not include gag clauses.
- Highmark will comply with applicable disclosure provisions of the CAA subject to the execution of an appropriate confidentiality agreement.

Effective Date: December 27, 2020 | **Enforcement Date:** January 1, 2022

Broker Compensation Disclosure

Consolidated Appropriations Act

Health Plan Responsibility

DESCRIPTION

Requires group and individual health plans to disclose to member direct and indrect compensation provided by the plan to an agent or broker associated with enrolling the member in coverage. Plans are also required to report to HHS on an annual basis prior to any direct or indirect compensation provided to an agent or broker.

Disclose compensation prior to enrollment

Requires health plans to disclose/report broker compensation

HHS Secretary

Effective Date: December 27, 2021 | **Enforcement Date:** January 1, 2022

Pharmacy Cost Reporting

Consolidated Appropriations Act

Health Plan Responsibility

DESCRIPTION

Requires Plans to submit annually to the tri-agencies a report detailing top drivers of prescription drug costs.

- Health Plan will be prepared to support this required reporting once additional regulations or further guidance is issued.

Effective Date: December 27, 2021 | **Enforcement Date: 12/27/2022**

Employer Responsibility — If pharmacy is carved out, coordinate with PBM

- The 50 most frequently dispensed brand prescription drugs and the total number of paid claims for each drug
- The 50 most costly prescription drugs by total annual spending and the annual amount spent for each drug
- The 50 prescription drugs with the greatest increase in plan expenditures over the preceding the plan year

- Total spending on health care services broken down by the type of cost
- Average monthly premium, including a breakdown of amounts paid by employers, participants and beneficiaries (where applicable)

- Any impact on premiums by rebates, fees, and other remuneration paid by drug manufacturers to the plan, its administrators or service providers, with respect to prescription drugs
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration

Advanced Explanation of Benefits — *Deferred*

Consolidated Appropriations Act

Health Plan Responsibility

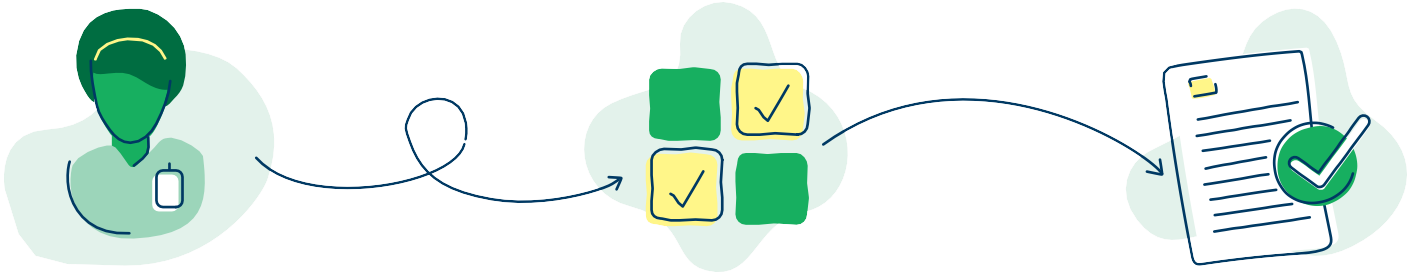
DESCRIPTION

Health plans are required to provide an advance explanation of benefits ("EOB") for scheduled services.

- Since we anticipate the tri-agencies to release data transfer standards, solution to be finalized once additional notice-and-comment rulemaking is published.

Effective Date: January 1, 2022 | **Enforcement Date:** Deferred

Employer Responsibility — Educate employees about new EOB



Provider submits AEOB request for scheduled service.

Insurer processes request, determines estimated cost and distributes AEOB.

Member receives AEOB.