MASSACHUSETTS

TRANSPARENCY IN COVERAGE RULE AND CONSOLIDATED APPROPRIATIONS ACT OVERVIEW AND FAQS

For Accounts and Brokers

June 2023

MASSACHUSETTS

TABLE OF CONTENTS

INTRODUCTION

Blue Cross Blue Shield of Massachusetts (BCBSMA) continues to work in support of and ensure compliance with the required capabilities for applicable provisions within both the Transparency in Coverage Rule (TCR) and the Consolidated Appropriations Act (CAA). However, significant legislation and regulations like these are accompanied by an iterative implementation process along with continued guidance and rulemaking by government agencies, and on ongoing basis, we will, of course, work to provide more information as it becomes available to ensure compliance with regulatory deadlines and in support of our accounts.

In areas where further clarification on final regulations and rulemaking are still needed, we have been taking actions and assessing required activity based on reasonable assumptions. We are providing good faith responses to the best of our ability and reasonable interpretation thus far. It's important to note that we will adjust our approach as we receive further clarification and/or changes to the requirements as they are made by the federal government. We will continue to provide updates as we receive more information by updating this document and posting updated versions on our broker and account portals.

Resources

Consolidated Appropriations Act document	Revised Certified IDR Entities Guidance and revised IDR Disputing Parties Guidance, which provide updates to conform with the recent Texas Medical Association, et al. v United States Department of Health and Human Services, et al. decision.
Provider No Surprise FAQs	
Transparency in Coverage Fact Sheet	
Transparency In Coverage FAQs	FAQs about the Federal IDR process, IDR entity qualifications and the application process, and fees.
NSA Independent Dispute Resolution (IDR) Links	
IDR payment dispute page	FAQs for providers and facilities about the No Surprises Act rules, Independent Dispute Resolution, and exceptions to the new rules and requirements.
List of certified entities	
Gag Clause Resources	Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process, which provides a high-level summary to assist in determining whether the Federal IDR process or a state law or All-Payer Model Agreement applies for determining out-of-network rates.
CMS FAQ 57	
CMS Gag Clause Website	
CMS Attestation Website	

TRANSPARENCY IN COVERAGE FINAL RULE (TCR)

On November 12, 2020, the United States Departments of Health and Human Services (HHS), Labor and Treasury issued a Final Rule entitled Transparency in Coverage (the Rule). The Rule aims to increase the availability and transparency of health care price information to consumers to enhance market competition and lower health care prices. The Rule follows the Hospital Price Transparency final rule, which required hospitals to make public a variety of pricing information and went into effect on January 1, 2021.
The Rule places requirements on fully insured group health plans and self-funded accounts, and health insurance issuers in the individual and group markets. It also applies to Qualified Health Plan (QHP) issuers and the Federal Employees Health Benefits Program. The Rule does not, however, apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision- or dental-only plans. Nor does the Rule apply to grandfathered health plans or to short term, limitation duration insurance. We do of course encourage accounts to consult with their legal counsel to determine if their plan is excluded if they are unsure.

The Rule's two (2) core requirements are to:

1. Disclose to the public [i] in-network provider negotiated rates, [ii] historical out-of-network allowed amounts, and [iii] drug pricing information through three (3) separate machine-readable files (MRFs) posted on an internet website.

   Important Update: The Departments have acknowledged that the subsequent CAA requirements, particular to prescription drug reporting, significantly changed the regulatory landscape since the TCR Final Rules were adopted. In particular, the Departments recognized concern about potentially duplicative and overlapping reporting requirements for prescription drugs.

   As a result, the Departments have deferred enforcement of the prescription drug MRF pending potential future notice/comment rulemaking.
   In addition, the Departments deferred enforcement of the TCR Final Rules' requirement to publish in-network (IN) negotiated provider rates and the historical allowed amount payments to out-of-network (OON) providers until July 1, 2022.

2. Disclose cost-sharing information upon request to a participant, beneficiary, or enrollee -including an estimate of the individual's cost-sharing liability for covered items or services via an online tool, and in paper or by telephone if requested.

The Rule adopts a three-year, phased-in approach for compliance with the Rule, which requires Plans and Issuers to provide:

- Public access to the in-network and out-of-network machine-readable files for plan (or policy) years that begin on or after July 1, 2022.
- Cost-sharing information to participants, beneficiaries, or enrollees for 500 specified items and services for plan (or policy) years that begin on or after January 1, 2023; and
- Cost-sharing information to participants, beneficiaries, or enrollees for all covered items and services for plan (or policy) years that begin on or after January 1, 2024

Further, in asserting that these initiatives will enable enhanced public access to health coverage information and that can potentially dampen the rise in health care spending, the Rule also allows (but does not require) health insurance issuers to receive credit in their Medical Loss Ratio (MLR) calculations for programs that create shared-savings for members resulting from their shopping for, and receiving care from lower-cost, higher-value providers.

OVERVIEW OF MACHINE-READABLE FILES: APPLICABILITY, ACCESS, AND USE

There are two files: the first shows negotiated rates for all covered items and services between the plan or issuer and in-network providers; the second shows both the historical payments to and billed charges from out-of-network providers. Historical payments must have a minimum of twenty (20) entries to protect consumer privacy. BCBSMA displays these data files in a standardized format and provides monthly updates. Please note, we do not at this time support arrangements that are carved out of the BCBSMA programs (i.e., carved out behavioral health care).

Covered Plans

The mandate requires plans to provide in-network and allowed amount rates for the below plans:

- Insured Individual and group medical plans
- Self-Insured medical plans

Non-Covered Plans

The below plans have been excluded from the mandate requirements:

- Grandfathered plans
- Excepted benefits (e.g., standalone vision, dental, and hearing plans)
- Retiree only plans
- Short term limited duration (STLD) plans
- Medicare plans
- Benefits managed outside of BCBSMA (i.e., carve out behavioral health care).

Website

https://Transparency-in-Coverage.Bluecrossma.com

As of July 1, 2022, the BCBSMA Transparency in Coverage website is publicly available to access . In accordance with the TCR there is no restriction on access through sign in or other mechanism that would create a barrier to access.

Data Arrangement

BCBSMA is leveraging the CMS allowed table of contents. The table of contents file combines multiple in-network/allowed amount rate files into a single index file. Plans that have same negotiated data (allowed amounts) can be grouped into a single array within the table of contents file.

Users can choose between “Fully Insured” files and “Self-Insured” TOCs by clicking on the “Select Files” dropdown. Clicking on “Download” will download the selected TOCs.

To manage file sizes, we provide links to all files required to make a complete local, regional, or national network.

Accessing the files

Due to the scope of these files and the JSON format, this means they are not intended for an average consumer to access. In fact, the size and scope will require sufficient memory and tools (i.e., JSON reader) to support access and review. Recommended browsers for access are:

- Chrome -Version 99.0.4844.74
- Edge - Version 99.0.1150.39
- Firefox - Version 98.0.1
- Safari - Version 15.3

Search capability is part of the hosted site allowing users to:

- Search for an MRF associated to a plan using the EIN/HIOS in the "Select Plan Type" field
- Search results display available files

Blue Cross Blue Shield of Massachusetts delivers the MRF files in the expected format that CMS requires. We are committed to ongoing support and updates to the machine-readable files.

Use of the files

An employer may access or share the data as needed to support their business. Should you decide to post files on your own site, you may download and host the files accordingly. Or you may direct to our site or the files and redirect a user to our source data.

Future Updates

CMS continues to make updates to the MRF file and data expectations. As such, BCBSMA maintains an active group supporting future updates and maintaining the data on an ongoing basis.

TRANSPARENCY IN COVERAGE FINAL RULE QUESTIONS AND ANSWERS

Does the rule apply to insurers and group health plans?

Yes. The rule applies directly to health insurers and to group health plans. The health insurer is responsible for implementing the requirements for fully insured group health plans.

A self-funded group health plan may contract with a third-party administrator to implement some or all requirements of the rule on behalf of the plan.

These rules do not apply to grandfathered plans, any group health plan or individual coverage in relation to the provision of excepted benefits (i.e., standalone vision, and dental plans), Personal Spending Accounts (i.e., HSAs, FSAs, HRAs, etc.) or other account-based group health plans, short-term limited-duration (STLD) insurance, Transitional Relief Plans, Medicare, and Medicaid.

We encourage accounts to consult with their legal counsel to determine if their plan is excluded if they are unsure.

MACHINE-READABLE FILES

What changes did the Tri-Agencies make to the Machine-Readable File requirements?

The Departments have deferred enforcement of the Transparency in Coverage Final Rules' requirement that plans/issuers publish MRFs relating to Rx drug pricing while it considers, through future notice/comment rulemaking, whether the Rx drug MRF requirement remains appropriate.

The Agencies have also modified to the file schema in effort to make it more valuable and to reduce file sizes. The most significant changes were:

- Addition of a table of contents which acts as an index of all network files that relate to reporting plans
- Allowance for reference files
- The inclusion of modifiers (optional based on use)
- Clarification of how payment of a percent of charges should be handled
- Allowance for provider groups and references allowing reporting at a provider group level
- Clarification of the handling of Provider SSN and NPI

What were the requirements for July 1, 2022, implementation?

The final rule requires health plans to provide publicly separate machine-readable files that include pricing information pertaining to 1) the IN negotiated rates with their providers; and 2) the historical payments to OON providers and their billed charges. These files must be made accessible via a public website at no additional charge, cannot require a log-in or account, and be updated monthly. The files must, in part, also include plan option/coverage identifier information; billing codes to identify items and services for claims processing; and all applicable rates.

Plans and issuers display these data files in a standardized format and will provide monthly updates. The historical prices are for the 90-day time-period that begins 180 days prior to the file publication date.

The final file schemas were published by CMS March 1, 2022

What format should the data be displayed according to the requirements?

Data files must be displayed in a standardized format, aligned with version 1.0 or later of the CMS Schema, and will be updated monthly. Based on the technical guidance issued by the Centers for Medicare and Medicaid Services (CMS), we utilize a JSON format.

Will BCBSMA create, maintain, and generate the publicly accessible website with all required machine-readable files on behalf employer clients?

BCBSMA manages a publicly accessible website with the machine-readable files for data we have (in-network, allowed amount). For accounts wishing to post these files on a separate website, they are able to access the files for download or leverage the URLs within the table of contents via our website that will be published.

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

At this time, we will only provide our data and data we have control of and will not include or merge other vendor's data. Data from account contracted third parties will not be included.

How often will data be updated?

Data will be updated in compliance with the regulations on a monthly basis.

How will you provide the data files to the employer for consumption? FTP site, secure file sharing (HTTPS), other?

The files are publicly available on our site, https://Transparency-in-Coverage.Bluecrossma.com. If employers would like to also post information on their site, they have the capacity to link to our public website, to download needed data or leverage the URLs to provide direction to the in network and allowed amount files.

How will employers be able to direct inquiries to the website? (i.e., can it be direct or via a link on the employer's site)

Employers can link directly to our public site, https://Transparency-in-Coverage.Bluecrossma.com. If employers would like to also post information on their site, they have the capacity download or point the URLs.

Does anyone wanting to access the machine-readable file have to open a user account?

Machine-readable files are publicly available to all users. No Account logins, passwords, register ration, or authorization are required.

How will BCBSMA respond to questions regarding any missing values such as NPI, procedure codes, etc.?

BCBSMA takes questions through standard channels and a team has been assigned to handle the research and review of inquiries. We have also included a stand-alone FAQ on the website to support general questions users may have regarding the data.

If an account opts to engage with a third party (such as a data warehouse or healthcare pricing vendor for enrolled members) to ensure compliance with the federal requirements, will your organization provide all necessary data elements to the third party? Can you elaborate on how you will interface with third parties?

BCBSMA will make any data mandated to be publicly available (i.e., in-network and allowed amount rate files) for public access and third-party developers will have access to this data. We do not intend for third party vendors to have unlimited access to BCBSMA's full load of data, but with agreed upon parameters and guardrails we will comply with appropriate third-party requests from vendors and assess on an individual basis.

Please specify the data file format (e.g., JSON, XML, YAML, etc.)

Our data file format is JSON.

PERSONALIZED DISCLOSURE OF OUT-OF-POCKET (OOP) COSTS (EFFECTIVE JANUARY 1, 2023, AND JANUARY 1, 2024)

The Transparency in Coverage Rule (TCR) requires insurers and plans to provide consumers with personalized cost-sharing information for both medical and prescription drugs, including estimates of their out OOP costs by service via an on-line tool, or paper, if requested. The Tri-Agencies later issued an FAQ that folded the CAA Cost Tool requirement to support cost estimation via the phone upon request, into the TCR, as well.

In general, the tools must make cost estimates available in real time via website and telephone, and within two (2) business days in paper form. Members need to be able to have access to their estimated cost-sharing liability for a covered service by a specific provider(s) or billing code/descriptive term, and such estimated cost-sharing liability needs to reflect any cost-sharing reductions the member would receive. The cost estimator tool must also allow members to compare costs across both in-network and out-of-network providers, as well as provide accumulated amount for deductible and/or out-of-pocket maximum at the time of the estimate request.

Beginning with plan years on or after January 1, 2023, the cost estimator tool (known at BCBSMA as the "Billing Code Cost Estimator") must disclose information on 500 items, services and prescription drugs identified in the final rule. Starting with plan years on and after January 1, 2024, the tool must list all covered items and services including prescription drugs.

Under the Transparency in Coverage Rule, what information must be included for consumers in the tool?

Health plans must make estimated personalized out-of-pocket costs information available to consumers along with the underlying negotiated rates for all covered items and services and out-of-network (OON) allowed amounts through a cost comparison self-service tool and in paper form if requested (if available in dollars or percent). Cost estimates will need to reflect current available information, indicating the consumers' financial liability for their healthcare items and services from providers of interest. The intent is to give consumers the opportunity to understand healthcare costs and their estimated cost-sharing liability based on their benefits and deductible and/or out of pocket accumulations, as well as the opportunity to compare costs across providers before obtaining care. According to the Transparency in Coverage rule, the cost estimator tool must be available to participants, beneficiaries and enrollees or their authorized representative. The tool must: include both in and out of network estimated cost (out of network costs may be dollars or percent); allow members or personal representatives to search based on billing code or description of the billing code; advise members of their current status towards deductible, out of pocket maximums and their accumulations to date; and provide cost estimate in paper format at the member's request.

What the is due date for consumers to have access to this information?

- January 1, 2023: an initial list of 500 shoppable services as determined by the Departments for plan years that begin on or after January 1, 2023.
- January 1, 2024: the remainder of all items and services will be required for plans years that begin on or after January 1, 2024.

What does all items and services include?

Beginning on and after January 1, 2024, the disclosure requirement for the cost comparison tool expands to all medical care covered by the insurer or plan including charges in connection with office visits, virtual care, medical tests, durable medical equipment, and prescription drugs.

How do consumers benefit from having access to a cost comparison tool?

There are several benefits of cost comparison tools as they relate to the consumer experience. Access to cost comparison tools allows consumers to shop for care, compare the cost and quality across providers and select providers that are best for themselves and/or family members. Members have greater insight to their potential out of pocket costs which allows them to prepare for the care they need while managing their finances. Understanding the cost of care in advance of receiving services, enables consumers to make informed and confident healthcare decisions and eliminates cost surprises which lead to negative experience and dissatisfaction.

Do you have experience with use of a cost estimator tool prior to implementation of the BCBSMA Billing Code Cost Estimator? If so, please describe previous/current capabilities.

We provide members access to quality and cost information through our integrated decision support platform Find a Doctor & Estimate Costs. Find a Doctor & Estimate Costs provides members with access to our enhanced level of cost estimates that integrates total costs (average allowed amounts) based on our Blues-negotiated rates and 12 months of historical claims data with member-level benefits and deductible/out-of-pocket maximums to calculate an estimate of out-of-pocket liability. The historical data is derived from the Blue Cross Blue Shield Axis® (BCBS Axis®) database, which is a nationwide repository of over 75 million claims that is updated semi-annually by all Blue plans.

Cost data is captured at the episode level, factoring in facility, professional and technical costs, to give a more realistic sense of cost. Costs displayed are the average allowed amounts, based on Blue Cross-contracted rates. The same provider quality data available through provider search is also integrated with cost data.

Can members get a written estimate?

Members who want more detail can use a simple online form to request a written estimate. To make sure estimates are as accurate as possible, we contact providers to get specific procedure and diagnosis codes. Massachusetts Collaborative also developed a Cost Estimate Worksheet that's useful for both patients and providers to ensure that they have all the necessary codes prior to requesting the written estimate.

CONSOLIDATED APPROPRIATIONS ACT, 2021 (CAA)

The Consolidated Appropriations Act, 2021 ("CAA") was signed into law in late December 2020. The sprawling legislation contains billions of dollars in additional stimulus funding in response to the COVID-19 pandemic, numerous tax law and benefit changes, as well as a wide-ranging set of health care legislation, among other areas of focus. With its enactment has come a considerably tight timeframe for implementation processes, with an effective date of January 1, 2022, now In place for many health care-specific provisions– and which has been further complicated to this point by a lack of critical regulatory guidance. The Tri-Agencies have released a FAQ, that modified timelines of some components of the CAA. These variations are indicated below.

Such provisions, as discussed in more detail further below, include:

- **Surprise Medical Billing Patient Protections**. Beginning Jan. 1, 2022, patients are protected from surprise medical bills that could arise from out-of-network emergency care, certain non-emergency ancillary services provided by out-of-network providers, and non-emergency services performed by an out-of-network provider at an in-network facility without the patient's informed consent.
    - Provider Reimbursement and Independent Dispute Resolution (IDR) Process. Providers not satisfied with the initial payment amount for surprise claims, may initiate negotiation of the paid claim with the payer. If a negotiated settlement cannot be reached, the IDR process may then be triggered by either party. Each party will submit a final offer for consideration by the arbiter (also known as "baseball-style arbitration"), along with supporting information. The IDR entity makes the final binding decision.
    - Application of Protections to Ambulance Services. Patients using air (but not ground) ambulance services are provided similar protections against surprise medical billing, and providers of air ambulance services and health plans will be provided a similar process for resolving disputed claims as outlined above.

- **Advanced Explanation of Benefits.** Requires individual and group health plans to provide an Advanced Explanation of Benefits ("AEOB") for scheduled services that includes a patient's information regarding network inclusion, contracted rate for a given item or service, out-of-pocket estimates, estimates of incurred amounts towards one's deductible/cost-sharing limits, and information on medical management requirements. The Tri-Agencies have recently deferred enforcement of this requirement and have indicated they will issue future rulemaking to support the future capabilities and timelines.

- **Continuity of Care.** For certain levels of care, Plans are required to give members the opportunity to request a transitional care period if a health provider is removed from a plan's network following termination of the network contract between the plan and provider.

- **Mental Health and Substance Abuse Parity.** Requires group & individual health plans and Medicaid managed care organizations to perform, document and to provide upon request comparative analyses of the design and application of non-quantitative treatment limitations (NQTL).

- **Enhanced Provider Data Requirements.** Requires commercial 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.

- **Changes to ID Cards.** Plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the plan or coverage, 1.) any deductible applicable to the plan, 2.) any maximum out of pocket limits applicable to the plan, 3.) telephone number, and internet website address where an individual can seek consumer/member assistance.

- **Rx Data Reporting.** Group health plans (fully-insured and self-funded) and health insurance issuers offering group or individual health insurance coverage must report plan-specific prescription drug spending and medical cost data annually to the Departments of Health and Human Services (HHS), Labor, and the Treasury.

  The data submitted by insurance companies and employer-based health plans (and other pertinent entities) is being collected in aim of:

  - Identifying major drivers of increases in prescription drug and health care spending;
  - Understanding how prescription drug rebates impact premiums and out-of-pocket costs; and
  - Promoting transparency in prescription drug pricing

  The report is due annually by June 1 of the calendar year immediately following the "reference year", which is the calendar year of the data contained within the prescription drug data collection (RxDC) report.

- **Gag Clause prohibition.** A group health plan or insurer may not enter into a provider agreement that would directly or indirectly restrict a group health plan or insurer from providing, accessing, or sharing certain claims or provider-specific cost or quality of care information. Plans and issuers must annually submit to the Departments an attestation that the plan or issuer is complying with the gag clause prohibition.

CONSOLIDATED APPROPRIATIONS ACT, 2021 (CAA) QUESTIONS AND ANSWERS

SURPRISE BILLING

Title I of Division BB of the CAA (the No Surprises Act) within the CAA establishes new protections from surprise billing and excessive cost-sharing for consumers receiving certain medical health care items and services. The No Surprises Act:

- Protects members from balance billing when receiving certain services under certain circumstances.
- Provides for patients to be responsible for only in-network cost-sharing amounts, and requires claims be applied to in-network cost-sharing, including deductibles and out-of-pocket maximums, in emergency and certain non-emergency situations.
- Also applies to air ambulance services (ground ambulance services excluded).

In addition to the prohibitions on surprise billing, the No Surprises Act requires providers and insurers to negotiate provider payments should either party not be satisfied with the proposed rate of payment. If the insurer and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) process, also referred to as arbitration, will be deployed to determine the reimbursement amount

This provision took effect January 1, 2022, for BCBSMA, and applies to all individual, small group, and large group fully insured markets and self-insured group plans, including grandfathered plans (excludes Medicare)[1].

Under the No Surprises Act, the CAA will require health plans to reimburse out-of-network providers and facilities in the situations where balance billing is prohibited. Will you be offering services to support this?

Yes, as of 1/1/22, as stipulated by the No Surprises Act, BCBSMA is engaged in multiple activities at the enterprise, functional, and operational levels structured to comprehensively address the various components of the CAA related to Surprise Billing, and to assure the plan is positioned as best as possible to support the requirements of the law.

Balance billing by out-of-network providers is prohibited with respect to certain emergency services and certain services provided by nonparticipating providers practicing at in-network facilities. Under the No Surprises Act member cost-sharing for No Surprises Act covered out-of-network (OON) services is based on the "recognized amount" which is determined as follows:

- In states that have adopted an All-Payer Model Agreement, (APMA), the payment amount pursuant to such agreement (e.g., Maryland).

[1] Individual (non-ERISA), Church (non-ERISA), Muni (non-ERISA), Labor, Student, small and large Commercial Group Plans (fully insured, self-insured, and grandfathered), FEP, TPA

- If the state does not have an APMA, an applicable state law methodology to determine the payment amount for such items/services.
- If the state does not have an APMA or state law methodology to determine the payment amount, the lesser of the billed amount or qualifying payment amount (QPA).

For No Surprises Act air ambulance services – member cost-sharing requirement must be the same as that applied to items/services provided by an in-network provider, and the cost-sharing amount Is based on the lesser of the billed amount or the qualifying payment amount (QPA).

Does BCBSMA abide by any state balance laws when adjudicating claims for both fully insured and self-insured accounts.

The federal Employee Retirement Income Security Act of 1974 (ERISA) governs self-funded health plans and preempts state insurance regulations. Under current Massachusetts laws, balance billing (again, pertaining only to fully insured accounts) is not explicitly prohibited and at present, there are no Massachusetts state laws that impact the application of the No Surprises Act in terms of adjudicating claims for either fully insured or self-insured accounts.

Of note and serving largely as a complement to the federal No Surprises Act, the Massachusetts state legislature has recently issued new requirements for providers under the state's "Patients First Act" to address surprise billing challenges in the private insurance and health care coverage markets. This state law, which like the federal No Surprises Act took effect in in January 2022 (though enforcement delayed until July 1, 2022) requires health care providers to tell patients how much they will pay for planned hospital stays, medical procedures, health care services, and referrals, based on the patient's specific health insurance plan. This includes notifying patients whether they are in-network or out-of-network. The Massachusetts Department of Public Health has released additional information on these requirements on providers and patient rights which can be found **here.**

Which entities will fulfill the role of IDR (independent dispute resolution)? Is this different from the entity that you currently contract with to negotiate disputed claims?

In accordance with the CAA, the federal government has accountability for certifying and selecting IDR entities that payers and providers may use. From the approved list, payers and providers together will choose one IDR entity for each particular case or group of cases. If agreement cannot be reached on the IDR entity, the federal system assigns the IDR entity for each specific case or bundle of cases.

How will BCBSMA ensure members are protected from balance bills where legislation requires that protection? Specifically, when plan participants encounter the following situations. Please provide specific recommendations, if available (i.e., cap reimbursement at % of Medicare).

- **Seek out-of-network emergency care**
- **Transported by an out-of-network air ambulance**
- **Receive non-emergency care at an in-network hospital but are unknowingly treated by an out-of-network physician or laboratory**

BCBSMA has worked to implement all provisions of the law that are required of health plans to achieve compliance and plans to process and adjudicate out-of-network claims as required by the law. Regardless of the amount BCBSMA reimburses the provider upon initial payment, the provider is prohibited from balance billing for certain services included under CAA without member consent. If dissatisfied with the

amount of payment, the provider may elect to negotiate with the payer, and if still seeking additional payment may proceed to IDR.

Although it is the responsibility of the provider not to balance bill under all circumstances covered by the law, health plans are required to implement systems to help support the intent of the law. BCBSMA has developed processes that will, for example, (i) assure plan designs comply with cost-sharing components of the law; (ii) identify claims falling under the scope of the law; (iii) adjudicate such claims in accordance with the law; (iv) generate and apply a Qualifying Payment Amount (QPA) reflecting the requirements of the law; and (v) facilitate claims negotiation and engagement in the IDR process.

Can you provide guidance on how BCBSMA is addressing surprise billing requirements?

BCBSMA has conducted an enterprise-wide implementation effort designed to achieve compliance with Surprise Billing legislation. BCBSMA is deploying a broad base of policy, operations, and technological resources to meet the requirements of the law and has active workgroups across the company working towards compliance with different surprise billing requirements. At a more specific level, BCBSMA is, for example, modifying system processes to identify claims that are covered by the law, configuring cost-share calculations that reflect the new requirements, developing methodologies for determining the Qualified Payment Amount (QPA), and evaluating approaches to negotiation and IDR to support effective and efficient processes in support of our accounts and members.

For out-of-network services, provide recommendations on reasonable and customary limits to protect the plan from fraud, waste and abuse and members from balance billing. In particular, do you recommend adding a reasonable and customary level of reimbursement for out-of-network facility charges (i.e., 150% of Medicare)? How will BCBSMA protect members from balance billing with this limit?

Current State: For fully insured and self-insured PPO plans with out-of-network benefits, BCBSMA has historically offered an out-of-network payment methodology designed to protect the plan from fraud, waste, and abuse and members from balance billing. Such methodology utilizes fair, reasonable, geographically adjusted, credible fee schedules as well as a program for negotiating out of-network fees where possible. Our standard design has priced claims at Medicare 150%. When no Medicare rate is available, the claim has then been priced using a third-party proprietary fee schedule meeting the attributes noted above. While members could be balance billed, the rate of payment was designed to be appropriately priced thereby discouraging balance billing. BCBSMA has also offered accounts a charge-based option and a Medicare 300% option. For the charge-based option and Medicare 300% claims for which there is no Medicare fee, eligible claims have been negotiated on a pre-payment basis, and all successfully negotiated claims have included a ban on balance billing.

Changes to Current State: For Massachusetts claims covered by the Act, we'll pay providers the lesser of charges or the Qualifying Payment Amount (QPA), which is generally the median of the contracted rates of the plan for the item, or service in the geographic region. For out-of-state claims, we'll pay providers the applicable Recognized Amount. The Recognized Amount, as defined in the law, is either: (i) an amount determined by an applicable All-Payer Model Agreement; or (ii) if there's no applicable All-Payer Model Agreement, an amount determined by a specified state law; or (iii) if there's no applicable All-Payer Model Agreement or specified state law, the lesser of the amount billed by the provider or facility, or the Qualifying Payment Amount (QPA).

Under the Surprise Billing Law, providers cannot balance bill members for certain types of services regardless of the amount of the health plan's initial payment. Should the provider wish to challenge the amount of the initial payment, the provider is required to negotiate with the health plan, and if not satisfied then submit the matter to Independent Dispute Resolution (IDR).

The Surprise Billing regulations have an exception – if providers have given patients 72-hour notice of their network status and an estimate of charges. Please explain how BCBSMA will know that a provider/facility has a waiver to balance bill patients. Please also confirm there will be operations in place to process these claims appropriately.

Surprise Billing legislation only allows balance billing for certain services covered by the law where the provider secures written consent from the patient at least 72 hours prior to the service.
The CAA requires providers notify health plans when notice and consent requirements have been satisfied by the provider. In compliance with the law and any current or future requirements, BCBSMA has developed procedures to operationalize receipt of notice and proper payment of the claim, including adjustments necessary when appropriate notice is received.

Confirm you will be amending your fully insured plan designs to be in compliance with the No Surprises Act (e.g., the requirement to cover emergency services provided in or out of network without any prior authorization and to cover OON emergency services as if they were received in-network).

To the extent necessary, BCBSMA has worked to modify fully insured plan designs, as required by the legislation, and accompanying regulations.

Where are you posting the required disclosure notice for members?

Disclosures that outline our members' rights and protections under the No Surprises Act are posted on our public BCBSMA website under the "Member Rights" section. The "Member Rights" section, and correspondingly These disclosures, can be accessed through the footer on MyBlue and Account Microsites. The Explanation of Benefits (EOB) we send to members when we pay bills covered by the law will contain information on No Surprises and direct members to the disclosures on member rights.

Why are accounts not receiving a 90-day notice for changes made to the Account Agreements based on the No Surprises Act?

The legislation, passed at the end of 2020, has been followed by Interim Final Rules, published 7/13/21, and a second set of rules late September 2021, which is roughly 90 days from the 1/1/2022 implementation date. BCBSMA has been focused on developing implementation plans in order to comply with the federal mandate. BCBSMA is not required to give a 90-day notice to accounts when changes made to Account Agreements are due to a federal mandate.

ADVANCE EOB (AEOB)

Effective January 1, 2022, the CAA requires providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a good faith estimate to the payer (if the patient is enrolled in a plan or insurance coverage and intends to use the coverage) three days in advance of a scheduled service. The AEOB will be triggered by the notification from the provider and/or facility or upon request of the patient of authorized representative. Individual and group health plans will be required to provide an advance EOB for scheduled services at least three days in advance of a service. If the service is scheduled

within three days of the request, the AEOB must be provided to the member within one business day and if the service is scheduled within 10 days of the request, the AEOB must be provided within three business days.

Advanced EOBs are to be delivered to members either electronically or via postal mail, as requested by the member and include service details received from the provider(s); the providers' network status; negotiated rate information and actual plan liability for the service; a good faith estimate of the member's cost-sharing liability for the service; and any relevant disclaimer information on medical management requirements that apply to the service.

Important Update: Given concerns from stakeholders regarding the ability to build good faith estimates as noted above, the Departments acknowledged that AEOB compliance was not possible by 1/1/22. The Departments intend to develop a new notice and rulemaking process to implement this provision; until that time, Departments will defer enforcement of AEOBs. Consistent with other carriers, BCBSMA is awaiting further direction and clarification from the Departments on specifics of this provision.

CONTINUITY OF CARE

The new protections for defined patients in the midst of a course of medical care are effective for the first plan year beginning on or after January 1, 2022. The Act determines timely notification to a member if a health provider is removed from a plan's network following termination of the network contract between the plan and provider. When this occurs, the plan or insurer must notify members who are receiving care from the provider that:

- The provider is no longer part of the plan's network.
- The participant has the right to continue receiving transitional care from the provider.
- The plan must cover the transitional care provided by that former plan network provider at the in-network coverage level during the transitional care period.

Plans are required to give the participant the opportunity to request a transitional care period. The period must extend for the remaining time that the participant is a patient at a continuing care facility or for up to 90 days after the plan participant(s) receives notification from the plan that the provider is no longer in their network.

Please confirm your intention to allow certain participants to receive up to 90 days of continued coverage at in-network cost-sharing rates when their provider moves out-of-network, as well as the parameters for coverage.

Yes - while BCBSMA continues to monitor for updated federal guidance pertaining to the Act's Continuity of Care (CoC) provision, this regulation is effective for plan years beginning on or after Jan. 1, 2022. For continuity of care, plans are asked to use good faith and reasonable interpretation to meet the 1/1/22 date. Additional guidance is anticipated in 2022. Enforcement is based on a safe harbor.

Will BCBSMA notify a "continuing care patient" in the event their in-network provider is losing their in-network status due to contract termination or plan change?

Yes - The CAA allows certain patients the opportunity to continue care if their provider or facility is no longer in the insurer/plan network. The plan must notify each member under the care of a network physician or facility of the opportunity for transition of care under the same terms and conditions as if

they were still covered by the plan. If the member elects this opportunity and is approved, continuity of care ends a) 90 days after the plan notifies the member or b) the date the member is no longer undergoing continuing care by that provider or facility, whichever is earlier.

Describe the process for that notification.

Under this process for notification and using the CAA definition of eligible continuity of care services, BCBSMA's CAA-compliant CoC letter applies to members where continuity of care services is identified. BCBSMA will send letters (with the continuity of care request form) out to any member identified who had 2 visits with the terminating provider in the last 13 months. Members who may be eligible would need to request continuity of care.

Please comment on your expected timing in accordance with the new regulations.

BCBSMA is in compliance related to our capacity to notify the eligible member of their CoC rights.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

BCBSMA has not made any determination regarding the potential of administrative fees as a result of these changes as we are evaluating the impact of the No Surprises Act legislation on administrative costs.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Since passage of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), BCBSMA has conducted compliance assessments. These ongoing analyses were initially conducted when implementing the statute as well as the Interim Final Rule issued in February 2010 (in effect through June 30, 2014), and the Final Rule effective July 1, 2014. Additionally, as part of more recent federal guidance, BCBSMA reviews and updates MHPAEA compliance activities. This work effort includes ongoing non-quantitative and quantitative compliance activities, including non-quantitative treatment limitations (NQTLs) comparative analyses as highlighted in recent DOL guidance (April 2021).

BCBSMA documents the result of these in-depth analyses, and determines that the processes, standards, and criteria, as written or in operation, that apply to mental health/substance use disorder services are comparable to and applied no more stringently than the processes, standards, and criteria, as written or in operation, that apply to medical/surgical services.

BCBSMA's multi-disciplinary MHPAEA compliance program includes a cross-functional MHPAEA/NQTL compliance committee of senior leaders. BCBSMA works closely with in-house and outside MHPAEA counsel.

Given the new requirements for health plans to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits as compared to mental health and substance use disorder benefits, will you be offering services to support this?

Yes, BCBSMA conducts and maintains NQTL Comparative Analysis, based on federal law and guidance released by the Departments of Labor, Health and Human Services, and Treasury, and will make NQTL documentation available to the Department of Labor or to accounts upon request. It is important to note that self-funded accounts are responsible for compliance with MHPAEA requirements. Upon request,

BCBSMA will provide certain information and otherwise assist self-funded accounts to respond to regulators; as well as conduct their own analysis of their plan's compliance with MHPAEA.

Please comment on your expected timing in accordance with the new requirements.

BCBSMA continuously reviews and updates NQTL comparative analyses.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

Currently, BCBSMA does not charge a fee for supporting DOL inquiries and DOL requests of information and NQTL documentation.

PROVIDER DIRECTORIES

Requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days. The requirements below are from the CAA legislative text, and it is assumed further clarification, detail and date confirmation for compliance will be detailed in the regulatory text sometime next year. We are working to mitigate, and plan based on limited current information, and may need to adjust our roadmap based on further specifics. We will continue to update this document as we receive more details.

Important update: Until further rulemaking is issued, plans and issuers are expected to implement provider directory provisions using a good faith compliance approach. Pending any future implementing rulemaking, the Departments clarify that good faith compliance requires plans and issuers to impose in-network cost-sharing where a participant receives items or services from a nonparticipating provider and the participant was provided inaccurate information by the plan or issuer through a provider directory or other response protocol.

- Requires plans to establish a response protocol to respond to member network questions within one business day and retain communications for at least two years.
- If a member provides documentation that they received incorrect information, the patient will only be responsible for in-network cost-sharing.
- Requires providers to update directory information and provide refunds to enrollees (in certain circumstances).
- Requires update of directory information within 2 business days of plan or issuer receiving from a provider or facility information.
- The data elements that must be updated in directory information are defined by the CAA:
  - For purposes of this subsection, the term 'provider directory information' includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

Please share your roadmap for making available to participants up-to-date provider directories, and participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts. In your response, please confirm and outline your ability to conform to the requirement that participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts.

Our provider directories are updated continuously, and date of update is noted. If data is incorrect and a member relies on the incorrect data and that is brought to our attention, we will initiate the appropriate claim adjustment to ensure the provider is made whole and the member is only held responsible for the in-network cost share.

Will you comply with the provider directory requirements on behalf of your employer clients?

Yes, BCBSMA is making good faith efforts in meeting all compliance requirements and our intention is to ensure full compliance with the CAA provider directory regulations.

How often will you update the directory?

We will comply with CAA requirements to validate and confirm provider data every 90 days. Additionally, we update our directory data as we receive information from providers and third-party vendors on a continual basis.

Will you notify employers of the update?

Given the frequency and volume of provider data changes we receive and process daily we will not be able to support account notification of updates but will ensure compliance with federal and state requirements for managing and presentment of provider directory information. We make available an online version of our directory that includes real time updates and date changes were made.

Will the versions be dated, so employers will know the updates are current?

Our online directory does include date information indicating when provider information was updated.

How will access to the directory be provided (i.e., directly or via an employer website)?

Our online directory is available to members and prospective members via our portal (bluecrossma.org).

If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how BCBSMA will administer the claim at the in-network level?

If we determine incorrect provider network data was used in accessing care, we will ensure we are compliant with CAA and process the claim at the in- network level for patient cost share, and ensure the provider is made whole at the out of network payment level.

Please comment on your expected timing in accordance with the new regulations.

We are making good faith efforts to be prepared for the compliance date.

Please advise, if any, on the administrative fees as a result of these changes.

The work effort to be compliant with CAA and any other regulations is part of our overall administrative budget.

How will BCBSMA adapt internal processes to comply with the following requirements regarding accuracy of provider directories: If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how BCBSMA will administer the claim at the in-network level.

If we determine incorrect provider data was used in accessing care, we will ensure we are compliant with CAA and process the claim at the in-network level for patient cost share, and ensure the provider is made whole at the out of network payment level.

ID CARDS

Plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the plan or coverage, 1.) any deductible applicable to the plan, 2.) any maximum out of pocket limits applicable to the plan, 3.) telephone number, and internet website address where an individual can seek consumer/member assistance.

Please indicate your intent to comply with ID card requirements to include deductibles, out-of-pocket maximums, phone number and website address to assist members.

BCBSMA is in compliance with the deductible and out of pocket maximum requirements. Phone number and web address are already included on the ID card.

Please confirm if new ID cards will need to be issued given the requirements to display INN/OON cost sharing and BCBSMA's ability to support this.

We have issued new ID Cards except for Medicare and Medex plans. Additionally, digital versions of the ID cards with the updated requirements are also available on the MyBlue member portal.

Please confirm no file changes/interfaces will be needed.

There will be no changes to the files currently being sent to BCBSMA by our customers as a result of the CAA mandate.

When will new ID cards be reissued?

BCBSMA began issuing new cards in Q2 2022. Digital cards also became available during Q2 2022.

Will there be a cost associated with reissuing ID card?

There will be no additional cost for reissuing the ID cards for our accounts or members.

What date does BCBSMA need renewal decisions to produce ID cards in a timely fashion?

We need 60 days in advance to produce ID cards by the required timeframe.

RX DATA REPORTING

Group health plans (fully-insured and self-funded) and health insurance issuers offering group or individual health insurance coverage must report plan-specific prescription drug spending and medical cost data annually to the Departments of Health and Human Services (HHS), Labor, and the Treasury. The data submitted by insurance companies and employer-based health plans (and other pertinent entities) is being collected in aim of: (i) identifying major drivers of increases in prescription drug and health care spending; (ii) understanding how prescription drug rebates impact premiums and out-of-pocket costs; and (iii) promoting transparency in prescription drug pricing

The report is required annually by June 1 of the calendar year immediately following the "reference year", which is the calendar year of the data contained within the prescription drug data collection (RxDC) report.

Please confirm what BCBSMA's plans for accommodating the CAA requirement on Rx Data Reporting?

For the first two reporting periods, BCBSMA has report RxDC data on behalf of its fully-insured and has also offered to do so on behalf of its self-funded accounts, for benefits which it administers. For those accounts that BCBSMA does not administer prescription drug coverage, we will provide support for some of the required reports, but the account is responsible for working with their pharmacy benefit manager (PBM) to ensure all other necessary reports are submitted.

What happens if an account is covered by multiple carriers (medical or pharmacy)?

CMS' RxDC reporting instructions notes that plans, issuers, carriers, and their reporting entities must work together so that each data file submitted to CMS is complete. However, more recent guidance from CMS states that if there are extenuating circumstances that prevent vendors from working with each other, the vendors should follow the RxDC reporting instructions to prepare and submit *independent* RxDC reports. Essentially, updated requirements suggests that each vendor, in certain defined "extenuating circumstances" can submit the files separately and consolidation across a singular file is not required.

Further, the recent clarification from CMS implies that under an eligible extenuating circumstance, if the Group Health Plan uses multiple TPAs or PBMs, a P2 should be submitted by the Group Health Plan which incorporates all TPAs and/or PBMs and EINs. We are referring to this as the Master P2. Then, each TPA or PBM will submit their own corresponding P2, along with the data files pertaining to coverage they provide. .

What actions should accounts take?

Fully-insured account	BCBSMA will complete CMS filing on behalf of the account for all pertinent data files; BCBSMA will include and submit all relevant/mandated data elements (medical, Rx) aggregated at the plan/group/market segment level (depending on the particular data file). Account is asked to participate in annual BCBSMA RxDC survey in order for BCBSMA to capture needed data not typically available but necessary for reporting purposes. There is no administrative fee tied to this option.
ASC account (Rx Carve-In)	BCBSMA will complete CMS filing on behalf of the account for all pertinent data files; BCBSMA will include and submit all relevant/mandated data elements (medical, Rx) aggregated at the plan/group/market segment level (depending on the particular data file). Account is asked to participate in annual BCBSMA RxDC survey in order for BCBSMA to capture needed data not typically available but necessary for reporting purposes. There is no administrative fee tied to this option. Account alternatively has the option to indicate its intention to fully or partially submit their data (pertaining to benefits administered by BCBSMA) on their own via the annual BCBSMA RxDC account survey. There is an administrative fee tied to this option.
ASC account (Rx Carve-Out)	BCBSMA will submit partial D1 file, absent total Rx claims/admin fees data, which must be provided by the account's outside PBM, full D2 file, and associated P2 files on the account's behalf. There is no administrative fee tied to this option. Account is responsible for submission of its missing D1 file information, and the D3-D8 files as these pertain specifically to prescription drug costs, trends, rebates, etc. Account alternatively has the option to indicate to BCBSMA its intention to fully or partially submit their data (pertaining to benefits administered by BCBSMA) on their own via the annual BCBSMA RxDC survey. There is an administrative fee tied to this option.

Please note that if an ASC account opts to either fully or partially opt-out of the BCBSMA RxDC filing process, then the account is responsible for submitting some or all of its data to CMS on its own behalf or via another contracted vendor.

AIR AMBULANCE REPORTING

Pertains to reporting requirements for health plans for air ambulance claims, and air ambulance carriers regarding their service history with HHS and Transportation departments on air ambulance services.

Services include the number of transports by payer mix, the number of claims denied by plans or issuers, and the reason for the denials.

This provision applies the reporting requirements for plans, issuers, FEHBP carriers and providers for two calendar years. Reports were set to be due 3/31/23 (for 2022 calendar year) and 3/30/24 (for 2023 calendar year).

While BCBSMA has already worked to collect the necessary air ambulance data, we are waiting for additional guidance on the timing and submission requirements for this reporting. While proposed rules did indicate a 3/31/23 first report date, the federal government has since indicated the enforcement date has been pushed out until further guidance can be developed. Based on recent information from the tri-agencies, we are not expecting to get any rule updates until August 2023. We will provide an update on this issue as more information is made available by the Departments.

GAG CLAUSE RULE

A group health plan or insurer may not enter into an agreement with a health care provider, network or association of providers, Third Party Administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or insurer from providing provider-specific cost or quality of care information or data, electronically accessing de-identified claims and encounter information or data for each enrollee or sharing that information or data with a business associate.

BCBSMA has already handled removal of gag clauses; internal process is in place to ensure that all new contracts are devoid of any prohibited gag clause language.

Plans and issuers must annually submit to the Departments an attestation that the plan or issuer is complying with the gag clause prohibition. This is referred to as the Gag Clause Prohibition Compliance Attestation.

The first attestation is due no later than December 31, 2023, covering the period beginning December 27, 2020 (the date the law was enacted) or the effective date of the applicable group health plan or health insurance coverage (if later) through the date of the attestation. Subsequent annual attestations, which cover the period since the last preceding attestation, are due on December 31 of each year thereafter.

For our fully Insured business, BCBSMA will provide attestation to HHS portal by December 2023. For self-funded and Level funded accounts, we will provide a confirmation of compliance to our customers in Q3, which they may use to attest on the HHS portal.

What is the scope of the Gag Clause requirements?

The gag clause prohibitions and attestation requirements apply broadly to all health insurance issuers offering fully insured or self-funded coverage in the group and individual markets, including grandfather and grandmother (transitional relief) plans, student health plans, individual coverage offered through an association, ERISA plans, non-Federal governmental plans, and church plans subject to the Code. However, plans and issuers otherwise attesting do not need to attest with regard to coverage that is solely an excepted benefit.

The following entities are not required to attest:

- Plans or issuers offering only excepted benefits,
- Issuers offering only short-term, limited duration insurance (STLDI),
- Medicare, Medicaid, CHIP or Basic Health Program plans,
- TRICARE, and
- the Indian Health Service program.

The Departments will not take enforcement action against plans that consist solely of health reimbursement arrangements or other account-based group health plans.

How are external customer arrangements handled?

Customers/plan sponsors with special arrangements and carve outs including are responsible for submitting their own attestation.

Do any contracts you are a party to contain a claim prohibiting disclosure of pricing terms ("gag clause") which will be prohibited under the No Surprises Act?

BCBSMA has reviewed our provider contracts to determine if they meet the required regulation and revised them as necessary to meet the requirements under the law.

What statement will we provide our self-funded customers regarding BCBSMA's compliance with the gag clause?

BCBSMA will provide the self-funded customer with a confirmation of compliance that the customer can use with their own attestation. BCBSMA confirmation of compliance to self-funded group health plans will assist self-funded customers in making necessary attestations. If the self-funded group has other networks or contractual arrangements with Third parties, they will need to gather information from them to complete the attestation.

Why isn't Blue Cross completing the attestation on behalf of self-insured clients?

Unlike fully insured accounts, self-funded groups may use other TPAs in addition to BCBSMA or may carve-out certain medical, pharmacy, and/or behavioral health services involving provider contract administration. As a result of such varied scenarios, BCBSMA is unable to file the attestation for a self-funded account, as we are only able to attest to our provider contracts pertaining to services that we administer on behalf of a given account. Given the potential variation of TPA activity and benefit administration across our self-funded groups, BCBSMA has developed a confirmation of compliance in aim of assisting our self-funded groups in making necessary attestations on their own behalf. If the self-funded group has other networks or contractual arrangements with third parties, they will need to gather information from them to complete the attestation. If a self-funded account has any specific concern or question about its TPA arrangement with BCBSMA, it's advisable for the account to review the relevant contract with its own legal counsel.

Today we have nondisclosure agreements (NDA) in place when we release this type of data – will NDAs still be required? Does the NDA need to be changed?

BCBSMA will still require nondisclosure agreements (NDA). The CAA does not prohibit reasonable restrictions on public disclosure of information. NDAs solely between BCBSMA and a vendor are not affected by the CAA.

We are working to ensure NDAs with all customers are executed consistent with the prohibition on "gag clauses" in the CAA.

Does the Gag clause provision apply to pharmacy providers?

Yes, the CAA prohibition on gag clauses in the CAA applies to agreements with pharmacies and applies to the network agreements BCBSMA currently has place.

GENERAL QUESTIONS

Please describe how your organization is coordinating the cross-functional, enterprise-wide implementation of the TCR and CAA requirements.

We have a broad cross functional team that has been in place for several months assessing requirements from both the TCR and CAA to determine our steps and solutions to solve for all transparency requirements. As we review requirements and our role and responsibilities to implement solutions that allow us to be compliant, we have also created individual provision-specific workstreams across the enterprise to ensure our teams are looking at issues in the most in-depth and robust process possible.

How and when will updates on your compliance with the various requirements of the TCR and CAA be disseminated to accounts?

We have created this external FAQ document which is available to our accounts and brokers on our portals and will be updated on a regular basis as needed.

How will you use price transparency as an opportunity to improve the consumer experience?

Over the past decade, we have been focused on providing greater transparency through our tools and service and will continue to focus on providing meaningful cost transparency tools to our members. Based on consumer research and the voice of the consumer analytics and studies we've conducted over the years; we know that increased cost transparency before treatment will help address the pain point of unexpected costs and help members plan their finances better before receiving treatment. Members want to better understand their healthcare costs so that they can maximize the value of their health plan and make the best-informed decisions on where to access affordable healthcare and manage their healthcare finances. Providing members with improved and expanded access to price transparency will enhance the experience by allowing them to anticipate the cost of care easily and accurately before receiving treatment. Members will be empowered and feel confident making informed decisions on where to access the best care for themselves and families while avoiding cost surprises.

Will you support the employer's communication to their employees on these changes & new resources?

We expect to continue to help, inform, and educate our members and other stakeholders on these changes and any new available resources and capabilities. We will communicate our approach as this develops. While we will continue to support our self-funded accounts as we do today, self-funded accounts will still be responsible for communicating to their employees and sharing materials and information as it's available.

Please comment on BCBSMA's readiness and associated timing and plans for member communications for TCR & CAA requirements. Are there any new administrative requirements expected from ASC Accounts as the plan sponsor?

We expect to continue to help, inform, and educate our members and other stakeholders on these changes and any new available resources and capabilities. We will communicate our approach as this develops. While we will continue to support our self-funded accounts as we do today, self-funded accounts will still be responsible for communicating to their employees and sharing materials and information as it's available. Additionally, we will continue to monitor updates on the regulations as there may be specific communication guidelines and expectations dictated by the TCR and CAA when published which may require specific activities for plans and self-funded accounts.