Kansas City

Transparency in Coverage Rule Consolidated Appropriations Act

Information for Employers

Updated June 1, 2022

Review our compliance with the Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TiC) and be aware of the steps your organization may take. When formal rule making occurs, changes may be made.

Transparency in Coverage Rule

TiC requires non-grandfathered group health plans and insurance issuers to publish certain healthcare price estimates and personalized cost-sharing information to plan members.

Machine-Readable Files

Insurers/plans must create and publicly post machine-readable files (MRF) with detailed in-network and out-of-network pricing data.

Compliance Status: We will post BlueCard pricing MRFs and out-of-network MRFs to our public website. Files will be in JSON format per CMS requirements and will be updated monthly. These will be general, not-employer-specific links, and multiple files may be generated for each group based on location of members and networks in use. For groups with custom pricing, we will generate the MRFs and post them to our public website. Users will have access to a search tool to locate files for a specific group. Files will be available for download without login by the July 1, 2022, enforcement date. **Click here** for more information.

Employer Actions: None

Price Transparency Tool

Insurers/plans must provide a price transparency tool for use by members with personalized, real-time estimates of cost of care. By January 1, 2023, the tool must include information for 500 items and services; by January 1, 2024, it must include all covered items and services.

Compliance Status: Blue KC offers price comparison and cost transparency capabilities through the Find Care experience on MyBlueKC.com. Blue KC's capabilities will be further enhanced throughout 2023 and 2024.

Employer Actions: None

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CAA provides protections for patients from surprise medical bills and a number of other health-related provisions.

Advance Cost Estimates and Explanation of Benefits

Upon being provided a good faith estimate by a provider/facility, group health plans must provide an advance EOB for scheduled services in three days (or if the scheduled service is less than 10 days away, in one business day) to give patients transparency into: which providers are expected to provide treatment and their network status; good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums; and if a service is subject to medical management and relevant disclaimers of estimates.

Compliance Status: On hold pending further guidance.

Employer Actions: None

Broker and Consultant Compensation Disclosure

Requires covered service providers who provide brokerage and consulting services to disclose to group health plan sponsors any direct or indirect compensation received for brokerage or consulting services.

Compliance Status: We have completed updates in our effort to comply with this provision.

Employer Actions: None

Continuity of Care

Requires a group health plan or health insurance issuer to provide 90 days of continued, in-network care for continuing care patients if a provider or facility leaves the network. Continuing care patients generally are individuals who are undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill.

Compliance Status: We have expanded our existing Transition of Care processes to extend in-network benefits to members who qualify for Continuity of Care (CoC) under CAA. Blue KC's compliance with certain CoC scenarios prescribed in CAA is pending additional clarification from regulators.

Employer Actions: None

Gag Clauses

This provision prohibits gag clauses on sharing cost and quality information in payer-provider contracting.

Compliance Status: We have completed updates in our effort to comply with this provision.

Employer Actions: None

Insurance ID Cards

Requires group and individual health plans to identify on insurance cards 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.

Compliance Status: Blue KC is adding the member's major medical deductible and applicable medical out-of-pocket maximums to member ID cards (physical and digital) across all applicable lines of business. A QR code has been added to member ID cards. When scanned, it will link to the member's benefit summary document, providing them access to their plan's deductible, ER copay, specialty copay, and more. The mandate also requires member ID cards to include a telephone number and website address, which ours currently do. Upon renewal, Blue KC will be reissuing the updated ID cards for plans effective on or after January 1, 2022. Updated ID cards will be reissued to all applicable lines of business. Blue KC is enclosing a flyer along with the ID card with an introduction and instructions for using the QR code.

Employer Actions: None

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Mental Health & Substance Abuse Parity

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

Compliance Status: Blue KC is waiting further rules and implementation guidance regarding the NQTL comparative analyses. Blue KC is responsible for ensuring fully insured plans are compliant with Mental Health Parity and Addiction Equity Act ("MHPAEA"). Self-funded group health plans are responsible for ensuring their plans are compliant with MHPAEA. Blue KC will provide discrete information to assist self-funded employer groups in performing the required analysis. However, we do not perform any MHPAEA testing for our self-funded groups, nor do we make any representations or warranties as to any self-funded plan design's compliance with MHPAEA.

Employer Actions: Fully insured employers should forward official regulator requests to Blue KC as soon as possible so that the NQTL comparative analyses can be completed within the timeframe set by the regulator. Self-funded group health plans should discuss compliance with their legal counsel.

Pharmacy Benefits and Drug Costs Reporting

Requires group and individual health plans to report annual data to HHS, the Department of Labor, and the Department of Treasury (Tri-agencies) on drug utilization, spending and rebates, as well as total spending on health care services by type (e.g. hospital, primary care, prescription drugs, etc.). Interim Final Rules allow the first two reports covering calendar years 2020 and 2021 originally due December 27, 2021, and June 1, 2022, respectfully, to be submitted prior to December 27, 2022. For calendar years beginning on and after 2022, the annual report will be due every June 1. For instance, data for calendar year 2022 is due June 1, 2023.

Compliance Status: We are positioned to meet reporting deadlines and are awaiting final rule making.

Employer Actions: Employer reporting may be required pending final regulation.

Price Comparison Tools

Requires group health plans and health insurance issuers to maintain a "price comparison tool," available via phone and website, that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider. Enforcement of this section is deferred until January 1, 2023, to align with comparable Transparency in Coverage requirements.

Compliance Status: We have completed updates in our effort to comply with this provision and are positioned to meet January 1, 2024, TCR Cost Tool requirements.

Employer Actions: None

Provider Directories

Health plans must establish a public-facing provider directory that contains certain information and establish a verification process to confirm the accuracy of provider directory information at least every 90 days.

If a member provides documentation that they received incorrect information about a provider's network status prior to a visit, the patient is only responsible for the in-network cost-sharing amount and the visit will apply to the member's deductible or out-of-pocket maximum, if applicable.

Compliance Status: Each Blue Cross and Blue Shield plan around the country is responsible for the verification process of providers in their area. Information from each plan is shared with the Blue Cross and Blue Shield Association, and that data is included in the online provider directory available to members.

We have updated our systems and processes accordingly.

Employer Actions Required: None

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Surprise Billing

Provides for patients to be responsible for only in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations (including air ambulance providers).

Prohibits providers from balance billing except in limited circumstances with patient notice and consent.

Provides access to an independent dispute resolution (IDR) process for providers and plans who cannot reach an agreement on payment.

For plan years starting on January 1, 2022, or later, plans must include on their public websites and each explanation of benefits a disclosure of the balance billing prohibitions included in the CAA and information on state and federal contacts if the member believes there has been a violation. Review Blue KC's at bluekc.com/caa/members.

Compliance Status: Surprise Billing requirements are in place as of January 1, 2022. We are processing claims subject to the No Surprises Act as in-network regardless of provider network status, and making provider payments, within the required timeliness standards. For claims subject to Surprise Billing, we are calculating member cost share based on the Recognized Amount, which is the lower of billed charges or the Qualifying Payment Amount (QPA). QPA is a calculated amount that is determined based on a median contracted reimbursement rate in a certain geographic area adjusted each year to account for inflation.

If a nonparticipating provider obtains written consent from a member to perform out-of-network services within a participating facility, the provider must send a copy of the consent to Blue KC and we will reprocess the claim accordingly.

We have completed updates in our effort to comply with the final rules regarding the IDR process and are providing negotiation services during the initial 30-day negotiation period.

Employer Actions: None