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CLAIMS MANAGEMENT, INC.

Employee FAQs

Transparency in Coverage and Consolidated Appropriations Act FAQs

Transparency in Coverage (TIC) Final Rules

In October 2020, the Departments of Health and Human Services, Labor, and Treasury released the Transparency in Coverage Final Rules (TIC). TIC requires that:

- Non-grandfathered health plans disclose, on a public website, three machine-readable files disclosing health care rates. The machine-readable files (MRF) must (i) contain provider rates for covered items and services, (ii) out-of-network allowed amounts and billed charges for covered items and services, and (iii) negotiated rates and historical net prices for covered prescription drugs. The files for (i) and (ii) must be made public beginning on July 1, 2022 (delayed from January 1, 2022); implementation of the third file has been postponed and no new date has been released.
- Health plans make price comparison information available through a web-based self-service tool and in paper form upon request for 500 items and services, for plan years beginning on or after January 1, 2023. Health plans must expand those tools to cover all items and services by January 1, 2024.

The Consolidated Appropriations Act (CAA)

On December 27, 2020, the Consolidated Appropriations Act (CAA) was signed into law. The CAA includes extensive transparency reforms, including some that appeared to overlap with TIC rules, but with more aggressive deadlines. The CAA represents the most significant changes to the private insurance market since the Affordable Care Act. The law:

- Requires plans to develop and make available price transparency tools, good faith estimates and an advanced explanation of benefits
- Restricts “surprise billing”
- Prohibits “gag clauses” in healthcare contracts
- Adds new mandates for ID cards, provider directories and continuity of care.

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1. When do these changes begin?

The provisions are effective for plan years beginning on or after January 1, 2022.

2. What do these changes mean for patients?

Surprise Billing Patient Protections

- **Grandfathered Plans Included.** Surprise billing protections apply to grandfathered as well as non-grandfathered plans.
- **Out-of-Network Care.** Patients may not be billed more than the network cost-sharing amount for services received from a non-participating facility or non-participating emergency room unless the patient receives notice of a provider’s non-network status in advance and consents to the non-network treatment and cost.
- **Pre-Authorization Not Required.** Plans may not require preauthorization for emergency services.
- **Patient Deductible.** Out-of-network surprise bills will be applied to the patient’s network deductible.
- **Continuity of Care.** If a provider changes network status (i.e., leaves the plan’s network), patients with certain needs may continue care with the provider for up to 90 days at network cost sharing rates to allow for a transition of care to a network provider (see “Health Plan Requirements).”

- **Inaccurate Network Directories.** If a patient provides documentation that he or she was provided inaccurate information from a plan or insurer about a provider's network status prior to treatment, the patient will only be responsible for the in-network cost-sharing amount.
- **ID Cards.** The CAA requires health plans to provide information on ID cards regarding the amount of the in- network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and Internet website address through which individuals may seek consumer assistance information.

3. What will be required of my health plan?

Health Plan Requirements

- **Expansion of External Review.** Plans must accommodate requests for external review following an adverse benefit determination when the applicability of surprise billing protections are in question.
- **Price Comparison Tool.** Effective January 1, 2023, health plans must offer a price comparison tool that is available online or via telephone. The tool must permit participants to compare cost-sharing among participating providers for particular services and items in a specific geographic location.
- **Identification Cards.** Health plan identification cards (both physical and electronic) must include the participant's in- and out-of-network deductible and out-of-pocket maximum amounts, as well as a telephone number or website address where the participant can obtain additional plan-related information.
- **Advanced EOBs.** Plans that receive pre-service notifications from providers must provide notice to participants that include:
  - Whether the provider or facility is a participating provider;
  - The good faith estimate included in the notification from the provider;
  - A good faith estimate of the amount the plan will pay for the services;
  - A good faith estimate of the participant's cost share;
  - A good faith estimate of the amount that the participant has incurred toward deductibles and out-of-pocket maximums;
  - For services that are subject to medical management, a disclaimer that such medical management is a prerequisite for coverage;
  - A disclaimer that the information provided is only an estimate and is subject to change; and
  - Any other information deemed appropriate by the plan.

Enforcement of this provision has been deferred pending further rulemaking.

- **Timeline for Claims Adjudication.** Health plans must make an initial payment or denial of claims to the billing provider or facility within 30 days of receipt of the claim.
- **Provider Directories.** Health Plans must maintain up-to-date directories of network providers, which must be available online or within one business day of inquiry. By 2022, plans must verify and update directories at least every 90 days. Directories must be available online and accessible to the public.
- **Inability to Comply with Deadlines.** HHS will develop regulations detailing extenuating circumstances or types of billing that may prevent plans or providers from complying with timelines.
- **Continuity of Care.** If a provider leaves the network, plans must provide 90 days of in-network care for participants in cases involving:
  - Pregnancy;
  - Treatment for serious and complex conditions;
  - Inpatient confinement;
  - Scheduled non-elective surgery; or
  - Terminal illness.
- **Disclosure of Balance Billing Rules.** Provide disclosures on the plan's public website and on each EOB regarding the requirements relating to prohibitions on balance billing.

4. What will be required of my providers?

Balance Billing Prohibited in Certain Situations. Facilities or providers may not balance bill for more than the network cost sharing amount:

- for emergency services received in a non-participating facility;
- for certain ancillary services performed in a participating facility by out-of-network radiologists, pathologists, emergency medicine providers, anesthesiologists, providers of diagnostic and neonatal services, assistant surgeons, hospitalists, and intensivists;
- for services provided by a non-participating provider in a participating facility when there is no participating provider who can furnish such services;
- for services provided by a non-participating provider or facility without the patient's informed consent. For consent to be valid, the patient must (i) be given notice of network status and an estimate of charges 72 hours in advance of services, and (ii) consent in writing to the out-of-network care. For appointments with less than 72 hours' notice, notice must be given the day the appointment is made.

Good Faith Estimate.
At least three days in advance of providing service (and not later than one day after service is scheduled), providers and facilities must verify the type of coverage in which the patient is enrolled and provide a good faith estimate, regardless of whether the patient is covered.

5. What are the newer FSA provisions?

FSA Rollovers.
Health and dependent care FSA participants may carry over unused balances from a plan year ending in 2020 to a plan year ending in 2021, and from a plan year ending in 2021 to plan year ending in 2022. The Act does not include a maximum carryover amount.

FSA Grace Period Extensions.
Plans may allow a health and dependent care FSA grace period for a plan year ending in 2020 or 2021 to be extended 12 months after the end of such plan year.

Health FSA Reimbursements.
An employee who ceases participation in the plan (e.g., terminates employment) during 2020 or 2021 may continue to receive reimbursements from unused balances through the end of the plan year in which such participation ceased (including any grace period).

Dependent Care FSA.
Dependent care FSA participants whose qualifying child turned age 13 during the pandemic may continue to receive reimbursements for dependent care expenses for the remainder of the plan year, provided the participant's regular enrollment period was on or before January 31, 2020. If a balance remains in the participant's dependent care FSA at the end of the plan year, the participant may receive reimbursements during the following plan year until the child turns age 14.

FSA Election Changes.
Participants may make health and dependent care FSA election changes for plan years ending in 2021, regardless of whether the participant experiences a qualifying event.