Transparency in Coverage Regulation and Consolidated Appropriations Act

External FAQs for JAA and MCS[1]
For purposes of this document, TPA refers to both a third-party administrator and a self-administered plan.

Note: For ASO/FI clients, please see the ASO/FI FAQ document.

Last Update: February 2024 (gray highlight indicates updates)

*****The information in this document does not constitute legal advice. Customers should consult their legal team for further questions or advice.*****

Transparency in Coverage – Final Regulation

General

Anthem supports meaningful transparency efforts that help consumers make informed health care decisions. In August 2021, the Department of Labor, in conjunction with the Departments of Health and Human Services (HHS) and the Treasury, (known collectively as the Tri-Agencies) issued updated guidance related to implementation of the Consolidated Appropriations Act (CAA) and Transparency in Coverage (TIC) final rule. The guidance delayed enforcement and provided good faith compliance safe harbors related to the implementation of a number of provisions of the CAA and TIC.

Due to the operational complexities and timeline challenges, the enforcement of key provisions including the prescription drug machine-readable file and advance explanation of benefits – has been deferred pending further guidance. This delayed enforcement provides much needed additional time to implement the requirements, while giving the Tri-Agencies time to align overlapping requirements and provide technical guidance for public comment and rulemaking.

The TIC regulation (Regulation) requires health insurers and group health plans (Health Plans) to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered healthcare items and services, Health Plans expanded those tools to cover all items and services effective January 1, 2024. CMS has indicated it will issue additional guidance on this provision and how it relates to the CAA price comparison requirements. The rule also required Health Plans to make public machine-readable files (MRF) beginning on July 1, 2022 (delayed from January 1, 2022) that contain the negotiated rates with in-network providers for all covered items and services as well as historical

[1] *MCS product is only sold in California.*

payments to and billed charges from out-of-network providers. The requirement to post an MRF containing the in-network negotiated rates and historical net prices for all covered prescription drugs by plan or issuer at the pharmacy location level is pending technical requirements and an implementation timeline, which the Tri-Agencies will provide in future guidance. The purpose of the rule is to provide transparency that federal regulators believe will promote consumer choice and competition among providers. In instances where rates cannot be disclosed in specified amounts (e.g., dollar), the Tri-Agencies will use a case-by-case approach to determine whether enforcement is appropriate.

Anthem will be issuing amendments to its JAA and MCS agreements on renewal to reflect the services Anthem will be providing under both the Transparency in Coverage regulation and the CAA as described at the end of this FAQ.

What areas will Anthem take responsibility for and make updates to be in compliance?
Anthem developed an implementation strategy for achieving the Transparency requirements, which is to provide a compliant solution which applies equally to its fully insured and self-funded clients for the data we administer and maintain.

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

What areas does Anthem feel are already in compliance with no change needed? Where are the current tools relative to the requirements as they are outlined by effective dates?
While Anthem does have member transparency tools in place and available currently for much of our business, changes will be required based on the current language in the Transparency in Coverage regulation.

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

List any subcontractors or third parties who are providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are issued.

What plans are subject to the Transparency Rule?
According to the Regulation, the Transparency Rule applies to health insurance issuers in the group and individual markets. It also applies to group health plans, including group health plans that are fully insured, as well as those that are self-funded. It also applies to Qualified Health Plan issuers and the Federal Employees Health Benefits Program. The Rule does not, however, apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision or dental only plans. Nor does the Transparency Rule apply to grandfathered health plans or to short term, limited duration insurance.

Machine Readable Files

What is a machine-readable file?
A machine-readable file is defined as a digital representation of data or information in a file that can be imported or read by a computer system for further processing without human intervention, while ensuring no semantic meaning is lost. The final rules require each machine-readable file to use a non-proprietary, open format. The machine-readable files for the data we administer and maintain will be made accessible through anthem.com. Clients can link to those files; but due to the size of the files, we will not be providing the data directly to our clients for them to put on their websites. Anthem will only be publishing the data it maintains, so if a plan uses a third-party vendor, such as a PBM, then the group should work with that vendor to determine whether it is providing a similar solution.

For JAA, we post the data attributable to network and non-network claims. Once additional regulatory guidance is issued, we will also provide the pharmacy information if pharmacy is purchased from Anthem.

For MCS, we post the data attributable to network claims only, since that is based on our contracted fee schedules.

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

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

Members can log in to anthem.com and use our cost transparency tools such as Find Care and Virtual Care to shop for health services and understand how costs differ from provider to provider.

How often will the machine-readable files be updated?
The regulation outlines that the files are required to be updated monthly on the first of each month.

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

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

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

How will client-specific machine-readable files be accessed on anthem.com?
Beginning July 1, 2022, Anthem has been publishing the machine-readable files for the plans we administer and maintain. These files are published on anthem.com and can be accessed using this link: https://www.anthem.com/machine-readable-file/search. This link can be added to the group health plan's public website to fulfill the group health plan posting requirement. This link will allow you to search for your files using your Employer Identification Number (EIN).

What is an EIN?
An Employer Identification Number (EIN) is a unique nine-digit identification code issued by the Internal Revenue Service (IRS) to a business. The CMS file layout requires group rate information to be loaded using the group EIN.

How will you monitor and validate your processes to ensure the ongoing accuracy of the data in the files?
Quality Audit (QA) processes are an integral part of our monthly file postings. Validation occurs at all points in the process including ensuring the source data from the multiple systems is being pulled in correctly, validating results of the data from the source system pull, and validation of data as it appears in production.

May a group health plan that does not have its own website satisfy the requirements of the TIC Final Rules with respect to posting the Allowed Amount file and the In-network Rate file on a public website of the plan, if the plan's service provider posts the Allowed Amount file and the In-network rate file on its public website on behalf of the group health plan?
Per CMS FAQ #37 published on June 17, 2022, (https://www.cms.gov/healthplan-price-transparency/resources/technical-clarification), if a group health plan does not have a public website, the plan may satisfy the requirements for posting the Allowed Amount file and the In-Network file by entering into a written agreement under which a service provider (such as a TPA) posts the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan. However, if a plan enters into an agreement under which a service provider agrees to post the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan, and the service provider fails to do so, the plan violates these disclosure requirements. The Departments intend to follow up with the issuance of formal guidance soon.

How do I know which file to pick for my product?
For the files posted by Anthem, the JSON File naming convention reflects the product name (e.g., PPO, HMO).

Please describe how Anthem will respond to questions regarding the files.
Please contact your TPA for any specific questions regarding the files. Your TPA will ensure that the question is routed to the appropriate team for response.

Will you provide the plan with any of the three machine readable files on a monthly basis including in-network rates, out-of-network allowed amounts, and prescription drug negotiated rates (for drugs dispensed under the medical plan)?
No, the machine-readable files will only be made available on anthem.com.

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

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

Cost Transparency Tool

The Transparency in Coverage regulation requires health insurers and group health plans to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services; health plans expanded those tools to cover all items and services effective January 1, 2024.

The CAA also requires plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

The answers in this section pertain to JAA plans only. For MCS, we expect that TPAs[2] can access the machine-readable files in order to get pricing to produce their own cost-transparency tool.

Will Anthem make the tool available to plan participants?
Anthem has updated its "Find Care" tool based on the mandates. The tool is based on data that Anthem has for Client and is based on Anthem's standard administration, such as processing of preventive care claims, and estimated out-of-network rate information. The estimated out-of-network rate information provided through the tool is not Provider-specific and, if Anthem does not provide utilization management services for Client, the tool will not provide detail as to whether prior authorization is required.

[2] *TPA refers to both self-administered plans and third-party administrators.*

Consolidated Appropriations Act (CAA) - Law pending final regulations

General

The CAA represents the most significant changes to the private insurance market since the Affordable Care Act. The law:

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

These provisions are described in more detail below but note that much of the important detail of this law will be determined by regulations that will be released in future rulemaking.

Anthem is working alongside other stakeholders to assess the operational complexities and timelines for implementation and continues to make recommendations to the Tri-Agencies who must develop these regulations.

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

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

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

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

The requirement for plans to provide a good faith estimate of charges and an Advance Explanation of Benefits (AEOB) when notified of a scheduled service by a provider are delayed, pending future regulatory guidance, with no final date set.

The Tri-Agencies also announced they would issue regulations to implement the ID card, provider directory, gag clauses on price and quality data, and continuity of care requirements, but would not do so prior to January 1, 2022. Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

Will there be a cost for compliance with the CAA?
Except for the Independent Dispute Resolution process, for plan years commencing 2023, there will be no additional charge for compliance changes, however, the new regulations will be taken into consideration when determining our administrative fees.

How does the Transparency in Coverage regulation relate to the transparency requirements included in the "No Surprises Act" aka the Consolidated Appropriations Act (CAA) published at the end of 2020?
These two separate laws make sweeping changes to the health care industry in an effort to further promote transparency. Although separate, they include overlapping provisions, notably the price comparison tool requirements.

The Regulation requires health insurers and group health plans to make an internet-based self-service tool available to enrollees beginning on January 1, 2023, that contains personalized out-of-pocket cost information and the underlying negotiated rates for 500 covered health care items and services; Health Plans expanded those tools to cover all items and services effective January 1, 2024.

The CAA also requires a price comparison tool; however, the requirements are not nearly as detailed as then tool considered under the Transparency in Coverage regulation. It still requires insurers to publish a tool for members allowing comparison of cost sharing amount for covered items and services.

The CAA also includes other transparency initiatives beyond the separate Transparency in Coverage requirements including:

1. Out-of-network providers to deliver to the patient's health plan a "good faith effort of an estimated amount" of all billing and services;
2. Providers to make available on their publicly available website information on their pricing for services;
3. Health Plans to provide members with an Advanced Explanation of Benefits (AEOB) prior to scheduled care or upon patient request;
4. Health Plans to maintain up to date provider directories; and,
5. Health Plans to remove gag clauses in their par-provider contracts.

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of certain provisions of the CAA. Specifically, enforcement of the price comparison tool requirements in the CAA were delayed until January 1, 2023, to align with the Transparency in Coverage regulation effective dates. The Tri-Agencies said they would use the delay to propose rules and seek public comment regarding whether compliance with the Transparency in Coverage regulation would satisfy the requirements to create a price comparison tool under the CAA.

Will you support the plan's communication to members on these changes and new resources?
We do anticipate communicating with groups as to our implementation activities for these laws. Groups may use these communications to develop communications for their member.

Are any subcontractors or third parties providing assistance to you in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan?
Anthem does not plan to use subcontractors for the machine-readable file. Use of subcontractors for other services will be determined once regulations are finalized.

Price Comparison Tool

The CAA requires plans to make available to members a price comparison tool to enable a member to compare the amount of cost-sharing the individual would be responsible for paying under the plan with respect to a specific item or service by a participating provider.

On August 20, 2021, the Tri-Agencies announced delays in enforcement of key provisions of the CAA. Specifically, enforcement of the price comparison tool mandate was delayed until January 1, 2023. The intent is to align the requirements of the Transparency in Pricing regulation with the Price Comparison tool requirements of the CAA. Additional rulemaking guidance is anticipated.

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

Provider Directory

The CAA requires plans to establish a verification process to confirm provider directory information at least every 90 days, including removing providers or facilities who are non-responsive. Plans must also develop a response protocol to respond to member network questions. Members who receive inaccurate information that a provider is in-network can only be liable for in-network cost-sharing.,

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the provider directory requirements but would not do so prior to January 1, 2022. These regulations or other regulatory guidance has not yet been issued. However, Health Plans are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date with a primary focus on ensuring members who rely on provider directory information that inaccurately depicts a provider's network status are only liable for in-network cost sharing amounts.

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

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

Will you accept responsibility for directory inaccuracies resulting in added plan cost?
The indemnification provision in the JAA or MCS agreement with Anthem will apply.

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

How often will you update the directory?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

Will you notify TPAs of the update?
No.

Will the versions be dated, so TPAs will know the updates are current?
Those processes will be determined as a part of our design based on implementation guidance from the final regulations.

How will access to the directory be provided (i.e., directly or via a plan sponsor website)?
The provider directory is/will be available through our website.

Mental Health Parity

What do the Strengthening Parity in Mental Health (MH) and Substance Use Disorders (SUD) provisions do?
Included as part of the Consolidated Appropriations Act of 2021 (commonly referred to as the Consolidated Appropriations Act (CAA)) were several measures intended to strengthen parity in MH/SUD benefits, specifically with Non-Quantitative Treatment Limitations (NQTLs). Importantly, if a group health plan that provides both Medical/Surgical (MS) benefits and Mental Health/Substance Use Disorder (MH/SUD) benefits and imposes NQTLs on MH/SUD benefits, the plan has to perform testing and make testing results available to the Tri-Agencies, or any state authority, upon request within 45 days of enactment of the Act (generally, no later than February 10, 2021). Plans must also document and make available the following information:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and MS benefits to which each such term applies in each respective benefits classification.
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and MS benefits.
3. The evidentiary standards used for the factors identified in 2 above when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and MS benefits.
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits, as written and inoperation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MS benefits in the benefits classification.
5. The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described above that indicate that the plan or coverage is or is not incompliance.

The Mental Health Parity and Addiction Equity Act (MHPAEA) currently requires NQTL testing, but the CAA creates more formal analyses and reporting. The DOL can begin requesting a comparative analysis report from group health plans beginning on February 10, 2021. The DOL will be issuing regulations on these new requirements.

What is a Non-Quantitative Treatment Limitation (NQTL)?
Mental Health Parity looks at two types of treatment limitations – quantitative and non-quantitative. Quantitative treatment limitations are the limits that apply to the coverage in the benefit booklets, such as cost-sharing and visit limits. Non-quantitative treatment limitations are behind-the-scenes administrative activities that take place but may impact coverage. Examples include credentialing, how we determine the amounts to pay providers, utilization management, creation of medical policies and case management. The law requires that we treat behavioral health conditions no less favorably than we

do medical conditions.

Who does this law apply to?
The law applies to all types of group plans, including self-funded clients.

How will Anthem comply with this law?
Anthem has created NQTL analysis for its standard processes and procedures (e.g., Credentialing, Case Management, Utilization Review, etc.), which are available free of charge upon request.

Are you able to conduct and provide a detailed written comparative analysis of the design and application of the Non-Quantitative Treatment Limitations (NQTLs) as contemplated by the Consolidated Appropriations Act?
Yes, for the services for which the plan utilizes Anthem's standard policies and procedures. Anthem has used the U.S. Department of Labor (DOL) self-compliance tool to analyze its compliance with the NQTL requirements.

Does the Anthem NQTL analysis apply to all plans subject to the law, whether fully insured or self-grouped?
The NQTL analysis applies to all fully insured business. To the extent a self-funded group utilizes Anthem's standard processes and procedures for the administration of the Plan (e.g., credentialing), Anthem's NQTL summaries will be applicable to any inquiries. However, if a group deviates from Anthem's standard procedures (e.g., modifies the prior authorization list) or doesn't use Anthem as a vendor for all of its plan administration (e.g., Rx, utilization management), then NQTL analysis would be the responsibility of the group or its other vendor(s).

Will Anthem provide required NQTL documentation?
Anthem will provide our NQTL analysis upon request, which reflects our standard processes and procedures. This NQTL analysis can be provided to groups, members, regulators or providers. It will be updated periodically. However, Anthem will not provide any analysis for NQTLs that are within the group's responsibility (e.g., benefit exclusions, Rx with a non-Anthem vendor, etc.).

Will Anthem perform the NQTL test for JAA/MCS Groups?
If a group uses our standard policies and procedures, our existing NQTL analysis will apply to them. For other NQTLs that are solely within the group's control (e.g., benefit design) or a requested deviation from our standard process (e.g., change to preauthorization listing), the group would be responsible for the NQTL analysis because they know why they made that determination. Also, if a group uses a vendor other than Anthem for an applicable NQTL, such as utilization management or pharmacy services, then the group will need to work with that vendor for any NQTL analysis.

What action is Anthem taking from the recent proposed rule on Mental Health Parity?
On July 25, 2023, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and Treasury (together, the Tri-Agencies) released new proposed rules that if adopted would alter the standards plans and issuers must meet to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Anthem will be meeting with internal subject matter experts to assess the proposed changes and consider perspectives from trade associations and employer clients as we prepare to develop feedback.

Please keep in mind the guidance is a proposal, and the proposed effective date of January 2025 is subject to change. Current regulations remain in place, and Anthem continues to operate to demonstrate compliance in accordance with these requirements.

Regardless of the proposal and its impact, Anthem recognizes the importance of mental health services and substance abuse services and remain committed to ensuring our clients and members have access to such services and care.

Advance Explanation of Benefits (AEOB)

The CAA requires health plans to provide an advance explanation of benefits (AEOB) for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the network status of those providers, good faith estimates of cost, cost-sharing and progress towards meeting deductibles and out-of-pocket maximums, as well as whether a service is subject to medical management and relevant disclaimers of estimates.

On August 20, 2021, the Tri-Agencies announced an indefinite delay in enforcement of the AEOB requirements. No new enforcement date was set.

Although we are awaiting regulatory guidance to confirm and begin implementation of the full solution, Anthem anticipates that the process that will be used will result in Anthem receiving the AEOB request from providers. We will price the request and send it to the TPA using a separate 837+ file from the current 837 claims file. The TPA will be responsible for generating and sending the AEOB to the member. The TPA will need to send a response file back to Anthem to close out the open request and a copy of the AEOB so that Anthem can respond to provider inquiries.

Note: The requirement to send the response back to Anthem is not applicable to MCS business.

Surprise Medical Billing

The CAA includes the “No Surprises Act” which mandates that patients are only responsible for in-network cost-sharing amounts, including deductibles, in emergency situations and certain non-emergency situations where patients do not have the ability to choose an in-network provider (including air ambulance providers). The law also prohibits providers from balance billing except in limited circumstances with patient notice and consent. The act also requires an independent dispute resolution process for providers and plans who cannot reach an agreement on payment.

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

What is the Qualifying Payment Amount (QPA)?
The QPA is the lesser of the median contracted rate in the metropolitan service area (MSA) for same or similar services and a same or similar provider or billed charge.

Will Anthem determine the Qualifying Payment Amount?
Yes, Anthem will determine the QPA so that the TPA can determine member cost-sharing.

How will Anthem define and evaluate service codes for purposes of determining the QPA?
Anthem will use the definitions outlined in the IFR. Service code means the code that describes an item or service, including a Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), or Diagnosis-Related Group (DRG) Code. Given the requirement that a separate QPA be established for each Service Code, Revenue Codes may also be considered Service Codes under the outpatient methodology. Based on a Final Rule published in August 2022, Anthem is aligning with the calculation of separate median contracted rates by provider specialty both in instances where its contracting process sets different rates for specialties and where the contracting process results in different rates for different specialties.

Does the No Surprises Act apply to ground ambulance as well as air ambulance?
No, the law applies only to air ambulance.

Can a JAA Payor utilize the QPA that Anthem supplies as the allowance for provider payment instead of the standard non-participating provider pricing and if so, will Anthem handle the IDR process?
Yes, the TPA can select the QPA as the payment amount instead of the standard non-participating provider pricing.

The CAA will require health plans to reimburse out-of-network (OON) providers and facilities in the situations where balance billing is prohibited. Will Anthem offer services to support this?
Yes, for our JAA plans Anthem is prepared to pay the provider directly where applicable. For MCS, the TPA is responsible for paying the provider directly.

Will Anthem handle the IDR process for the group?
Anthem will not handle the IDR process for our MCS groups. For our JAA business, it depends If Anthem pricing is used, Anthem will perform the IDR process. If Anthem pricing is not used, Anthem will only perform IDR for states in which a Host Blue, as defined in the JAA agreement, processed the claim. The plan sponsor will be responsible for the IDR process for Anthem's 14 states.

Groups will be charged the fees assessed by the arbitrator.

Will you assist clients in negotiations with out-of-network (OON) providers prior to the start of arbitration?
If Anthem is handling the IDR process, we will negotiate with OON providers. However, the group will be charged any fees related to IDR.

Do you have a list of certified IDR entities?
The list of certified IDR entities is available at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

What can the client expect in regard to IDR fees and expenses?
CMS issued the following guidance on the ranges of fees that can be expected for Independent Dispute Resolution for calendar years 2023 and 2024:

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

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

[i] *IDR Administrative Fee Guidance 2023 FAQs*
[ii] *October 2022 Fee Guidance Calendar Year 2023*
[iii] *IDR Process Fees Final Rule (12/21/23)*

Will the IDR Fee be charged to the JAA client under the claims account or as a direct charge to the client?
The IDR Fee will be direct billed.

If the IDR Fee is billed up front and the plan sponsor is determined to be the prevailing party, would the fee be refunded to the JAA client?
The administrative IDR fee is not refundable. It is a charge by the Federal Government to use the Federal website and process. The Arbitrator Fee or CIDRE Fee will only be charged to the client if the provider prevails in arbitration or if the dispute is settled before the arbitrator's decision.

How will these fees show on the ASO client invoice?
They will be in the summary section and then broken down in the detail section as well.

If the IDR Fee is billed up front and the plan sponsor is determined to be the prevailing party, would the fee be refunded to the JAA client?
The administrative IDR fee is not refundable. It is a charge by the Federal Government to use the Federal website and process. The Arbitrator Fee or CIDRE Fee will only be charged to the client if the provider prevails in arbitration or if the dispute is settled before the arbitrator's decision.

Is there a defined timeline for the Negotiation and IDR Process?
Yes, CMS defines a specified timeline for the negotiations and IDR process including a 30-business day open negotiation period prior to IDR. See the link below for details on the timeline: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period

ID Card Requirements

The CAA requires health plans to provide information on ID cards regarding the amount of the in-network and out-of-network deductibles, the in-network and out-of-network out-of-pocket maximum limitations, and a telephone number and Internet website address through which individuals may seek consumer assistance information.

On August 20, 2021, the Tri-Agencies announced they will issue regulations to implement the ID card requirements but would not do so prior to January 1, 2022. These regulations or other regulatory guidance has not yet been issued. However, Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

ID cards should be issued consistent with the Anthem ID Card manual, which has been updated.

Prohibition on Gag Clauses

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

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

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

> *Anthem represents that the administrative services provided under its Administrative Services agreements are consistent with the requirements set forth in Section 201 of the Consolidated Appropriations Act, 2021.*

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

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

Anthem's standard provider contract language and our JAA/MCS agreements include a provision stating that the parties will comply with applicable law. Therefore, any "gag clause" in the agreements will cease

to apply as of the law's effective date.

Have your participating provider contracts been revised to remove any language that restricts cost information sharing except for reasonable restrictions as permitted by the CAA, to allow plan sponsors to complete the attestation required?
Anthem's provider contracts are administered to comply with the law, including the restrictions placed on Gag Clauses by the CAA.

Continuity of Care

The CAA requires health plans to provide in-network coverage for 90 days of continued care to members whose provider or facility leaves the health plan's network when the member is undergoing treatment for a serious and complex condition, pregnant, receiving inpatient care, scheduled for non-elective surgery, or terminally ill.

On August 20, 2021, the Tri-Agencies released FAQs noting that they will issue regulations to implement the continuity of care requirements but will not do so prior to January 1, 2022. Plans and issuers are expected to implement based on a good faith, reasonable interpretation of the requirements by the January 1, 2022, compliance date.

Describe how you will implement the requirement to allow continuation of care for individuals when their health care provider is terminated from the Network, under ERISA Section 718 and PHSA Section 2799A-3.
We currently have a process for notifying TPAs of providers leaving the network. The TPA or designated entity will then notify impacted members based on their review process. The TPA will need to notify Anthem if a member has elected continuity of care so Anthem can price the claim using in-network reimbursement amounts. This process is contained in a document already shared with a TPA.

Pharmacy and Other Health Reporting

The Consolidated Appropriations Act requires health insurers offering group or individual health coverage and self-funded group health plans to report annual data to the Tri-Agencies on drug utilization and spending trends. The reporting must include total spending on healthcare services by type, such as for hospital, primary care, or prescription drugs. The reporting must also include rebate information and its effect on member costs.

The required reporting templates include:

- Plan Lists (Individual and Student, Group Health Plan List, and FEHB Plan List)
- Data Files (reporting of aggregated data based on state and market segment)
    - Premium and Life-Years Reporting
    - Spending by Category Reporting
    - Top 50 Most Frequent Brand Drugs Reporting
    - Top 50 Most Costly Drugs Reporting
    - Top 50 Drugs by Spending Increase Reporting
    - Rx Totals Reporting
    - Rx Rebates by Therapeutic Class Reporting

    - Rx Rebates for the Top 25 Drugs Reporting
- Narrative Response

On August 20, 2021, the Tri-Agencies announced a delay in enforcement of the pharmacy and other health reporting requirements until the issuance of new regulations. The new compliance date was December 27, 2022, for reporting years 2020 and 2021. Future years reporting will be due on June 1 annually (i.e., 2023 data will be due on June 1, 2024).

An Interim Final Rule was issued on November 17, 2021, including instructions for this reporting that were subsequently updated. Critical reporting detail continues to be provided.

According to the reporting instructions, the reports may be submitted by different entities based on the information required in the report. For example, for a self-funded group, the Group Health Plan or TPA may submit the Spending by Category reporting, while the PBM submits pharmacy related reports such as the Top 50 Most Costly Drugs report.

Will Anthem complete the reporting for JAA/MCS business?
No. Please consult with your TPA and any carve-out vendors you work with for guidance regarding the reporting submission for JAA/MCS business.

Note: If the JAA group has CarelonRx (formerly IngenioRx) coverage, CarelonRx will do that filing for the relevant portions (e.g., D3-D8) in aggregate for the data it maintains and administers. A Plan List and narrative file will also be submitted.

Why isn't Anthem doing the Pharmacy Reporting for JAA Groups?
There are two data file reports that are the responsibility of the health plan or its third-party administrator – D1 and D2.

- D1 reports the premium and life-years for the plan and its enrollees.
- D2 reports plan spending by category.

The TPA's claim system will have the most accurate and timely data for the report, so Anthem has made the decision to defer this reporting to the TPA and not include JAA business in our reporting. A health plan or its third-party administrator would also submit a separate Plan List and narrative file along with these Data Sheets.

Why can't Anthem create the D1 report?
Anthem does not maintain all of the information on its systems for this report, so the TPA would be the better resource. For example, the report requires information on ASO and other TPA fees. Anthem has no insight into how much the TPA charges for its administration of the plan. Without this information and other information, we also cannot calculate the premium equivalent values for the plan.

Why can't Anthem create the D2 report?
Once again, the TPA has the data required to create this report, data for which Anthem does not have access. For example, calculating total spending includes claims reported within the period but still in the process of adjustment or payment. The TPA would have more accurate knowledge of claims in the process of adjustment (e.g., a claim denial that has been overturned on appeal, but the adjustment not yet been sent to Anthem). Similarly, the plan must exclude third party liabilities. We do not have insight into claims that the TPA may be evaluating for workers compensation or other types of

subrogation (Anthem does not handle subrogation for most groups outside of California). We also do not have any insight into whether the group maintains any claims reserves.

Air Ambulance Reporting

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

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

A proposed regulation on the Air Ambulance reporting provision of the Consolidated Appropriations Act was issued on September 16, 2021, with a request for comments/feedback.

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

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

Will Anthem submit the reporting on behalf of clients?
Based on the proposed regulation, Anthem is moving forward with the development of the reporting with the intent to submit the reporting on behalf of our clients, including JAA clients. We will continue to monitor and provide any updates as additional regulatory detail is received and will advise if there is a change that impacts the approach.

Will this reporting be client specific?
No, the reporting will include all air ambulance claims for Anthem.

MCS – Please contact your TPA for information regarding the submission of Air Ambulance reporting.

JAA Contract Language

Article 1, Consolidated Appropriations Act ("CAA"). The Consolidated Appropriations Act of 2021 (42 USC 300gg, et seq. and 29 USC 1185, et seq.), as amended, and regulations promulgated thereunder.

Article 1, Paid Claim Definition, subparagraph (4):

4. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Subject to Article 16 as applicable, Paid Claims shall include any Claim amount paid as the result of a settlement, judgment, or legal, regulatory, or administrative proceeding brought against the Plan and/or Anthem, or otherwise agreed to by Anthem, with respect to the decisions made by Anthem regarding the coverage of or amounts paid for services under the terms of the Plan. Paid Claims also includes any amount paid as a result of dispute resolution procedures.

Article 2(d):

Consistent with the requirements of the CAA, Anthem shall provide Members and potential Members access to an online directory of Providers contracted with Anthem ("Provider Directories"). Additionally, Anthem shall ensure that Members and potential Members have access to the InterPlan directory of Providers via a website sponsored by BCBSA. Anthem grants Employer the permission to link to Anthem's website to allow Members to access Provider Directories and other available information, including information needed to comply with requirements of applicable law such as posting of machine-readable files.

Article 2(o):

o. Anthem shall assist Client or its designee with compliance with the following requirements under federal law as of the applicable effective date:

1. Include recognized amount (qualified payment amount) when transmitting surprise billing Claims under the Agreement to enable Client to calculate Member cost sharing.
2. Notify Client or its designee in the event of Provider termination from the network for continuity of care administration.
3. Unless waived by the Client, Provide Member cost transparency tool access through anthem.com for the benefits and rates administered by Anthem if listed in Schedule A for the fee set forth in Section 3.B of Schedule A. The tool is based on data that Anthem has for Client and is based on Anthem's standard administration, such as processing of preventive care Claims, and estimated out of network rate information. The estimated out of network rate information provided through the tool is not Provider-specific and, if Anthem does not provide utilization management services for Client, the tool will not provide detail as to whether prior authorization is required.
4. Provide reasonable assistance to Client or its designee in generating advance explanation of benefits upon Provider request. Administration of independent dispute resolution process for non-Network Provider Claims (including non-network air ambulance Provider Claims) ("IDR Process") as set forth under the Consolidated Appropriations Act as follows:
    - *a.* For services in the Anthem Service Area:
        - *i.* When Anthem pricing is used, Anthem will administer the IDR Process.
        - *ii.* When Anthem pricing is not used, Client is responsible for the IDR Process and, notwithstanding anything to the contrary in the Agreement, Anthem authorizes

Client or its designee to contact Providers directly for purposes of the IDR Process.

b. For services outside of the Anthem Service Area:
    i. The Host Blue or Anthem will administer the IDR Process.
    ii. If Client would like to administer the IDR Process for a particular Claim, Client or its designee will request permission, as applicable, from the Host Blue through Anthem in advance of the negotiation and within 2 business days of receipt of the negotiation request. If the Host Blue approves the request, Client will be responsible for the IDR Process and, notwithstanding anything to the contrary in the Agreement, Anthem authorizes Client or its designee to contact Providers directly for purposes of the IDR Process.

In all cases except (a)(ii) above, Client or its designee will notify Anthem within 2 business days of receipt that an independent dispute resolution request has been received.

5. Upon request, provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Client in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.

6. Post machine readable files for the services Anthem administers for the Plan on anthem.com.

Article 10(f):

This Agreement shall not be construed to restrict the use or disclosure of information that: (1) is public knowledge other than as a result of a breach of this Agreement; (2) is independently developed by a Party not in violation of this Agreement; (3) is made available to a Party by any person other than the other Party, provided the source of such information is not subject to any confidentiality obligations with respect to it; (4) is required to be disclosed pursuant to law, order, regulation or judicial or administrative process, but only to the extent of such required disclosures and after reasonable notice to the other Party; or (5) is required to be disclosed to a Member.

Section 3.B of Schedule A:

Member Cost Transparency Tool Access. Included in the Base Administrative Services Fee

Fees and Costs for Independent Dispute Resolution. Notwithstanding anything to the contrary in the Agreement, Client shall assume liability for payment of all fees and costs, including but not limited to arbitrator fees, charged to or paid by Anthem as part of independent dispute resolution processes.

MCS Contract Language

A new Article 2(k):

k. Anthem shall assist Client or its designee with compliance with the following requirements under federal law as of the applicable effective date:

1. Include qualified payment amounts when transmitting surprise billing Claims under the Agreement to enable Client to calculate Member cost sharing.
2. Notify Client or its designee in the event of Provider termination from the networkfor continuity of care administration.
3. Upon request, provide the non-quantitative treatment limitation analysis for the standard services that Anthem provides under the Agreement. Anthem will also provide reasonable assistance to Client in the event of a regulatory audit for compliance with the Mental Health Parity and Addiction Equity Act.
4. Post machine readable files for the in-network services Anthem administers for the Plan on anthem.com.