Consolidated Appropriations Act (CAA) and Transparency in Coverage Rule (TCR) Overview and Frequently Asked Questions

For use with customers, brokers, and consultants

Updated October 11, 2023

AmeriHealth further sharpens efforts on transparency

AmeriHealth HMO, Inc., and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth) continues to implement the Consolidated Appropriations Act (CAA) and the Transparency in Coverage Rule (TCR). The federal government has issued guidance about the CAA and TCR, and AmeriHealth understands that the federal government will be issuing additional guidance. The guidance issued by the federal government will impact the AmeriHealth implementation of the CAA and TCR.

AmeriHealth has an enterprise-wide implementation program to ensure its compliance with the CAA and TCR.

AmeriHealth will continue to update these FAQs as AmeriHealth receive additional guidance and updated FAQs will be communicated via the *Market Edge* newsletter. AmeriHealth will be in compliance with the CAA and TCR by the required compliance dates. This FAQ can always be accessed on the AmeriHealth Business Hub, https://www.amerihealth.com/resources/for-employers/business-hub.html. To easily access a provision section in this FAQ, click on the line item on the Table of Contents on the next page.

AmeriHealth

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Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 (CAA) was signed into law in December 2020. The CAA includes many provisions that affect how health insurers and group health plans provides health care coverage. Since the CAA was enacted, the federal government issued guidance about the CAA. The federal government issued guidance that it is delaying enforcement of certain provisions of the CAA and will take a good faith compliance approach to other provisions.

The CAA includes the following provisions:

Surprise Medical Billing Patient Protections.

For plan years beginning 1/1/2022 forward, members are protected from surprise medical bills that could arise from out-of-network emergency care, air ambulance services provided by out-of-network providers, and for out-of-network care provided at in-network facilities.

- **Provider Reimbursement and Independent Dispute Resolution (IDR) Process.** An IDR process between a health plan and provider can be used if the health plan and the provider cannot agree about reimbursement for the provider's services.
- **Application of Protections to Ambulance Services.** Members using air ambulance services will be 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. Ground ambulance services may be protected against surprise medical billing depending on the circumstances of the ground ambulance service.

Advanced Explanation of Benefits.

Upon request, a member can receive an Advanced Explanation of Benefits (AEOB) from a health plan for scheduled services. In the AEOB, a health plan will inform the member about, among other things, the contracted rate for a given item or service, out-of-pocket cost estimates, estimates of incurred amounts toward the member's deductible/cost-sharing limits, whether the service is available from an in-network provider and information on medical management requirements. The federal government issued guidance that enforcement of the AEOB requirement will be deferred pending further guidance.

Price Comparison Tool.

Cost-sharing information to be made available for services and covered items. Both the TCR and CAA included price comparison tool components. Enforcement of this requirement has been deferred to 2023 pending further guidance.

Continuity of Care.

For certain levels of care, health plans are required to give members the opportunity to request a transitional care period if a health provider is removed from the health plan's network following termination of the network contract between the health plan and provider. Health plans are expected to implement using a good faith, reasonable interpretation until additional guidance is issued.

Enhanced Provider Data Requirements.

Requires commercial health 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 to health plans' inquiries for verification. Health plans must also make provider directories available to members. CAA also requires that health plans establish a response protocol to respond to member requests as to whether a certain provider or facility is in-network. If a member provides documentation that they received incorrect information from the

provider directory or from the response protocol established by the CAA, the member will only be responsible for in-network cost-sharing.

Changes to ID Cards. Health plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the health plan or coverage:

1) any in-network and out-of-network deductibles applicable to the health plan,
2) any maximum out of pocket limits applicable to the health plan,
3) telephone number, and internet website address where an individual can seek assistance.

Health plans may design their ID cards using various methods to comply with the law, including the use of Quick Response (QR) codes to display information beyond the applicable major medical deductible and applicable out-of-pocket maximum. The federal government expects issuers to use a good faith, reasonable interpretation of the law.

Broker and Consultant Compensation Disclosure. Effective 12/27/2021, for individual health insurance plans, the health insurer must disclose to members, and report to HHS, any direct or indirect compensation that the health insurer pays to an agent or broker associated with plan selection or enrolling individuals in health insurance coverage beginning with contracts executed on or after 1/1/2022.

Pharmacy Benefit and Drug Cost Reporting. Requires health plans to report information on health plan medical costs and prescription drug spending. The first submission deadline to CMS was December 27, 2022 (2022 is the submission year; 2020 and 2021 are the reference years). Future annual report submissions will be due by June 1st of each year (reference year is prior calendar year).

Air Ambulance Reporting. Requires health plans to submit two years of claims data to be compiled by HHS for the publication of a comprehensive report.

External Review/Complaint Process. Allows for external review process to determine whether surprise billing protections are applicable when there is an adverse determination by the health plan.

Remove Gag Clauses on Price and Quality Information. Effective 12/27/2020, prohibits gag clauses on price and quality information to prevent health plans from entering into contracts with providers, networks or associations of providers, third-party administrators, or other service providers offering access to a network of providers that prohibit health plans from disclosing provider-specific cost or quality information. Additional guidance is expected in 2023 on how health plans and issuers should submit their attestations.

Mental Health and Substance Abuse Parity. Effective 2/10/2021, 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).

Consolidated Appropriations Act, 2021 (CAA) Questions and Answers

Q: Will AmeriHealth be in compliance with the CAA by 1/1/2022?
A: AmeriHealth is committed to meeting the requirements of the CAA applicable to it by the compliance dates.

Advanced EOB (AEOB)

Q: What plans does AmeriHealth have for accommodating the CAA requirement to provide AEOBs to members in 2022?
A: For participating providers, AmeriHealth is using the PEAR Portal for providers to submit AEOB requests; for non-participating providers, the request for AEOBs can be made via a customer service request. The mode of delivery to the member will be based on the member's preference on file – paper (mail) or electronic (via the portal or through email).

Q: Even though enforcement is deferred until further guidance, are you continuing to develop solutions based on available guidance should this go into effect in the near future?
A: AmeriHealth will comply with the law by the mandatory compliance dates.

Q. Please provide a sample AEOB.
A: AmeriHealth will share a sample AEOB when additional guidance is issued by the federal government.

Q. How will AmeriHealth obtain and maintain member email addresses to send these AEOBs electronically?
A: AmeriHealth will maintain members' email addresses through the current AmeriHealth member portal. If members do not have access to the member portal, they can contact customer service at the number on the back of their ID card to update their preferred method of communication.

Cost Comparison Tool

Q: What are the requirements for January 1, 2023 and January 1, 2024?
A: The cost estimation tool for 500 shoppable services was made available on January 1, 2023. The cost estimation tool for all services must be available by January 1, 2024.

Q: Will the AmeriHealth current cost comparison tool(s) be used as a price transparency tool?
A: Yes.

Q: Will AmeriHealth make an internet-based self-service price comparison tool available to members for the initial 500 "shoppable" services for insured customers that will allow the member to obtain a potential cost-sharing liability (i.e. estimate) for covered items and services from a particular health care provider?
A: Yes.

Q: Will the tool will be available to all enrolled members?
A: Yes. The tool is available.

Q: Will the tool be offered at no added cost to the plan sponsor or members?
A: Yes.

Q: How will the cost comparison tool be made available to members (e.g., online self-service and/or by phone)?

A: The cost comparison tool is available through amerihealth.com and the AmeriHealth mobile app. AmeriHealth can also produce cost estimates on behalf of members by calling customer service (i.e., by phone).

Q: Will the internet based self-service tool allow members to search for cost-sharing information for an in-network covered item or service on the 500 "shoppable" list by searching the following features: provider name, location of service, facility name, billing code, and dosage of covered medicine?
A: AmeriHealth will comply with the law and display all required fields.

Q: Will the internet tool allow members to refine and reorder search results based on geographic proximity of in-network providers and the amount of the member's estimated cost sharing liability for the covered item or service, to the extent the service for cost sharing information for covered returns multiple results?
A: The AmeriHealth tool will provide all required functionality.

Q: Will the internet tool allow members to search for an OON allowed amount, percentage of billed charges, or other rate that provides a reasonably accurate estimate of the amount a group health plan or insurer will pay for a covered item or service provided by OON providers by inputting a billing code, descriptive term, location, etc.?
A: The AmeriHealth tool will provide all required functionality.

Q: Will AmeriHealth comply with the requirements to provide price comparison guidance by phone and website (tool), allowing members to compare cost-sharing applicable under the plan with respect to the furnishing of a specific item or service, taking into account the plan year, geographic region, and providers?
A: AmeriHealth will comply with the law as required by the compliance date and provide a standard compliance implementation. Anything custom would need to be requested by the groups. The current AmeriHealth tool is already compliant for the majority of the AmeriHealth business.

Q: What are the benefits of the care cost estimator tool? What are the search capabilities in the price comparison tool?
A: The care cost estimator tool helps members save money and avoid unplanned expenses by allowing them to search and compare providers by estimated price based on their health plan. This tool will display provider details, quality information such as reviews, and the estimated out-of-pocket costs for a wide range of common procedures and office visits.

Q: Will AmeriHealth make the same information that is required in an internet-based self-service tool available in paper form at the request of a participant?
A: Yes.

Q: Will AmeriHealth provide the price comparison in paper form upon request without an added fee?
A: Yes.

Q: Will AmeriHealth mail the paper response no later than 2 business days after the participant's request is received?
A: Delivery of the estimate will be conducted according to individual member preference. AmeriHealth will comply with the requirements of the law.

Q: As the final rule allows AmeriHealth to limit the price comparison printed paper request to 20 providers, will AmeriHealth notify a member who requests the price comparison in paper that there is a provider limitation?
A: Yes.

Q: Can a member call the customer service number and ask for the price comparison information by phone?
A: Yes.

Q: As required by the legislation, please confirm AmeriHealth will identify any service or specific item where AmeriHealth requires a prerequisite or prior authorization? If yes, please outline how the member will be aware of any prerequisite or prior authorization.
A: Yes, AmeriHealth's tool will display required pre-requisites and disclaimers.

Q: Will AmeriHealth inform a member inquiring of OON provider services of the possibility of balancing billing (if applicable as not all states allow balance billing)? If yes, please outline how the member will be notified of the potential for balancing billing.
A: Yes. AmeriHealth's tool will display required messaging concerning OON services and costs.

ID Cards

Q: Will AmeriHealth issue new ID cards to display in-network/out-of-network applicable deductibles and out-of-network out of pocket limits, telephone number, and internet website address?
A: Yes. As of 1/1/2022*, ID cards are being re-issued based on the member/group renewal date (on or after 1/1/2022*) and are available on the portal. Members of large groups with benefit changes will also receive updated cards upon renewal, unless the group decides otherwise.

*1/1/2022, ID cards will be available in the new formats on the portal. They will be re-issued based on customer decision for large group customers.

Q: Will there be any additional fees?
A: There will not be any additional fees related to the new ID cards.

Q: Please confirm no file changes/interfaces will be needed.
A: At this time, AmeriHealth does not anticipate any file changes or interfaces will be needed. There will be a modification to the existing file sent to the AmeriHealth ID card vendor.

Q: Can AmeriHealth share a mockup of the ID cards?
A: Mockups of ID cards are available and can be shared upon request.

Q: Will cards be printed for newly enrolled members and/or members making changes be compliant with the new regulations?
A: Yes, all new members will receive new ID cards upon enrollment. Existing members will receive the new ID Cards if their groups are making benefit changes – based on renewal date. For example, a group that renews with benefit change on 1/1/2022 will receive new ID cards in late December. A group that renews with benefit change on 3/1/2022 will receive their ID cards in February.

Q: Will members receive new ID cards even if there were no benefit changes to their plan for the coming year?

A: No, only members of the groups with benefit changes will receive new ID Cards. However, new digital ID Cards will be available on the member portal and mobile app.

Continuity of Care

Q: Will AmeriHealth be in compliance by the effective date?
A: The current continuity of care policy for AmeriHealth network providers is compliant with the requirements of the CAA.

Q: What is the process to ensure continuity of care?
A: The current continuity of care policy is compliant with the requirements of the CAA. AmeriHealth notifies its members when a network provider leaves the network, and its members can outreach and request continuity of care, which is subject to Medical Director review.

Q: Do members receive a network disruption letter that indicates options for continuity of care in certain instances and action they need to take?
A: The current "Continuity of Care Coverage" process is compliant with the requirements of the CAA. AmeriHealth notifies the members when contracted provider leaves the network. The notice includes directions for member to follow.

Q. Will AmeriHealth identify individuals that qualify as "continuing care" and send them any required notices?
A: AmeriHealth currently communicates with members when providers are no longer part of the network. AmeriHealth will be compliant by the required compliance date.

Q: Will AmeriHealth allow certain members 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?
A: The current continuity of care policy is compliant with the CAA. Up to 90 calendar days of continuity of care is offered to the member through the current period of active treatment for an acute condition or through the acute phase of a chronic condition, after which they must seek care from a provider within the network specified by their product. Continuity of care determinations are made based on medical necessity.

Provider Directories

Q: Will AmeriHealth be in compliance by the effective date?
A: AmeriHealth is committed to meeting the requirements by the required compliance dates. AmeriHealth Provider Directory updates meet the requirements of the CAA.

Q: Has AmeriHealth established a protocol for responding to requests?
A: AmeriHealth will continue to use existing protocols in place to respond to member requests.

Q: What is being done to ensure frequent data updates?
A: Internal processes have been modified to update the required fields in the provider directory based on requirements of the CAA.

Q: What is the process to confirm a member relied on inaccurate provider directory information from the carrier website, and what steps will AmeriHealth take so that cost—sharing required by the law is applied to the claims for services for emergency care, from an out-of-network provider at an in-network hospital or ambulatory surgical center or from an out-of-network air ambulance provider?

A: AmeriHealth has an existing process performed by Customer Service to ensure cost-sharing reflects the participating status of the provider based on member request. The member must provide proof he/she received incorrect information on the provider's participation status. Proof of an incorrect provider directory entry should be either that the online provider directory is still displaying an out-of-network provider as in-network, or the member has print screen/printout of the directory listing the out-of-network provider as in-network.

Q: Will the required balance billing disclosure be present on the site and EOBs by the effective date?
A: Yes.

Q: Will AmeriHealth notify employers of directory updates?
A: No, AmeriHealth will not be able to support account notification when updates have been made. The updated date of the directory is listed on the directory site.

Q: If data will be provided through Plan-hosted website, will employers have the option to request a data feed for their employer-hosted website?
A: There are no plans to support new data feeds to employer hosted websites. For customers with feeds currently in place, there will be no changes to those data feeds.

Q: How will access to the directory be provided (i.e., directly or via an employer website)?
A: The AmeriHealth provider directory is available on the AmeriHealth public sites and on the member portal.

Q: If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how AmeriHealth will administer the claim at the in-network level?
A: AmeriHealth updates the online provider directory daily. Members who rely on incorrect information in the provider directory will not be liable beyond the in-network level of benefits and applicable cost-share.

Q: Do the AmeriHealth online provider directories comply with the requirements of the CAA?
A: Yes.

Q: Describe the process by which the accuracy of the AmeriHealth provider directories is maintained in order to ensure ongoing compliance with the requirements of the CAA.
A: Internal processes were modified to update the required fields in the provider directory based on the CAA's requirements.

Broker and Consultant Compensation Disclosure

Q: Will AmeriHealth be in compliance with the new disclosure requirements related to broker and consultant compensation by the effective date?
A: Yes. If you use a broker to help facilitate your member enrollment, their compensation is a flat fee per member, per month. This is paid by AmeriHealth. Your monthly premium will be the same whether you choose to use a broker or not. In addition, your broker may receive a bonus if certain sales thresholds are met.

AmeriHealth expects that brokers provide the above link or a printed copy of the linked document to all of their applicants, whether through their application pdf for on exchange, or a separate copy for paper applications, or applicants submitted through Pennie.

Surprise Billing

Q: How is AmeriHealth working to comply with CAA's No Surprises Act provisions?
A: AmeriHealth is continuing to review the No Surprises Act and any guidance and/or regulations issued by the federal government implementing the No Surprises Act. We are also working with our trade associations and the NJ Department of Banking and Insurance to determine how the new Federal requirements intersect with the existing NJ surprise billing law. AmeriHealth will comply with the No Surprises Act by the compliance date.

Q: What should a member do if they receive a surprise medical bill that is otherwise prohibited under the new regulations?
A: Cost Information for Out-of-Network Treatment is available on https://www.amerihealth.com/resources/for-members/index.html. Members can also call customer service number on the back of their ID card.

Q: Describe any services in support of compliance with CAA surprise billing protections that will be subcontracted or outsourced to NextGen. List the name of each party and services provided by each.
A: AmeriHealth is using NextGen as a platform vendor.

Q: Will you timely provide the air ambulance reporting on behalf of the plan to HHS?
A: AmeriHealth will comply with the air ambulance reporting provision of the CAA by the compliance date.

Q: Describe the steps AmeriHealth has taken to ensure compliance with the CAA's requirements regarding balance billing for out-of-network emergency claims and out-of-network services provided at in-network facilities.
A: Consistent with the requirements of the CAA, AmeriHealth made certain revisions to its claims processing system so that the specific out-of-network claims described in the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, AmeriHealth has developed a communication plan to inform members and providers about the CAA.

Q. For the out-of-network services protected from surprise medical billing (i.e., emergency room, air ambulance, and non-emergent services received by an OON provider at an IN facility), can AmeriHealth confirm the amount that AmeriHealth is using for the initial payment to the OON providers? Is AmeriHealth using the Qualifying Payment Amount or the allowable charge?
A: The QPA methodology used by AmeriHealth complies with the requirements of the CAA.

Q: As related to the AmeriHealth out-of-network claims administration and cost containment programs for services NOT subject to the CAA's surprise billing protections, describe any recent or anticipated forthcoming changes to your capabilities, program offering, fee structure, or other features. Include all program updates, regardless of whether in parallel to changes for services subject to CAA protections.
A: AmeriHealth is not planning any changes to the surprise billing protections other than changes required by the CAA.

Q: Will AmeriHealth administer "involuntary" OON claims subject to the CAA's surprise billing protections?
A: Consistent with the requirements of the No Surprises provision of the CAA, AmeriHealth made certain revisions to its claims processing system so that the specific out-of-network claims described in the No

Surprises provision of the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, AmeriHealth has developed a communication plan to inform members and providers about the No Surprises provision of the CAA.

Mental Health Parity and Addiction Equity Act ("MHPAEA") - CAA

Q: In the event of DOL investigation of customer's plan, will you provide the appropriate documentation or substantiation for purposes of demonstrating MHPAEA compliance?
A: AmeriHealth will assist the customer and provide appropriate documentation in response to a DOL subpoena.

Q: MHPAEA requires compliance with the financial and quantitative treatment limits (apply on the same basis between mental health and substance use disorder benefits and other medical/surgical benefits). Will AmeriHealth provide this analysis upon request in a timely manner?
A: For insured plans, financial requirement and QTL testing is required.

Q: Are there additional fees to perform this analysis?
A: There is no fee for financial requirement or QTL courtesy testing.

Q: Upon an official request from a regulator, will AmeriHealth perform the comparative analysis required by the CAA to show compliance with federal mental health parity? If yes, is there an additional fee for this service and what is the standard turn-around time to deliver the analysis?
A: AmeriHealth will assist the customer and provide appropriate documentation in response to a DOL subpoena. AmeriHealth will provide its analysis of its templated, standard health plan designs. There is not an additional fee at this time for the analysis of the AmeriHealth templated health plan designs. Turnaround time to receive the analysis of the AmeriHealth templated health plan designs is approximately five business days.

Q: Will AmeriHealth also be available to assist the customer/regulator with any subsequent follow up questions?
A: Yes, AmeriHealth will be available to assist the customer/regulator with any subsequent follow up questions.

Q: Please confirm the customer will not be charged for this support.
A: There will be no charge at this time for the standard analysis.

Reporting Requirements

Q: The Rx Benefits and Cost Reporting requirements outline the reporting of specific prescription drug spend and certain medical cost data annually. For the top 50 drugs: Paid claims for most frequently dispensed, Annual amount spent by total plan/coverage spend, Greatest prior year plan spend, Total health care spend, and Premiums and rebates.
A: Yes.

Q: What are the important deadlines for Rx Reporting?
A: The first submission deadline to CMS was December 27, 2022 (note, 2022 is the submission year; 2020 and 2021 are the reference years). Future annual report submissions will be due by June 1st of each year **(reference year is prior calendar year).**

Q: [Updated as of 10/11/23] **Do insured customers have to do anything for the submissions?**

A: For the June 1, 2024 and subsequent Section 204 – RxDC submission to CMS, AmeriHealth will collect information for Form 5500 Plan Code, the employee contribution information, and the PBM name through the Employer Portal.

Q: What types of plans will AmeriHealth include the required data for?
A: AmeriHealth will include the required data for all types of plans. AmeriHealth will include the required data for all coverages, managed by AmeriHealth.

Q: Are there additional fees?
A: At this point AmeriHealth does not anticipate additional cost for the reporting service.

Q: Does AmeriHealth expect to be a "reporting entity" and is AmeriHealth able to support aggregate reporting at the state level of all required medical data elements on behalf of customers pursuant to the Pharmacy Data Collection (RxDC) instructions provided by CMS in late November (RxDC reporting instructions (PDF))?

This includes (not limited to):

- **Total spending**
- **Spending categories (hospital, primary care, specialty care, clinical health services and equipment, and wellness services, prescription drug spend under the medical plan)**
- **Rx totals for spending for drugs covered under a non-pharmacy benefit**

A: AmeriHealth will be a "reporting entity" and will produce reports based on RxDC reporting instructions, including aggregate spending amounts based on required categories.

Q: Is the customer required to make any decisions as part of the RxDC reporting requirements?
A: No.

Q: What decisions does AmeriHealth need from plan sponsors and by what date? For example, certain PBMs require the plan sponsor to confirm whether they wish the PBM to submit data on their behalf or wish the PBM to send the data to the plan sponsor for the plan sponsor to submit.
A: AmeriHealth does not need a decision from customers.

Q: What is the AmeriHealth EIN?
A: The EIN number is available by contacting your Account Rep.

Q: Will AmeriHealth submit files on customer's behalf for P2 – Group health plan list, D1 – Premium and life years, D2 – Spending by category, D3 – Top 50 most frequent brand drugs, D4 – Top 50 most costly drugs, D5 – Top 50 drugs by spending increase, D6 – Rx totals, D7 – Rx rebates by therapeutic class, and D8 – Rx rebates for the top 25 drugs?
A: Yes. AmeriHealth will create reports based on CAA requirements for all products managed by AmeriHealth, using information currently available in our source systems. Customers with pharmacy coverage not managed by AmeriHealth will not be included in D3-D8 files.

Q: Will AmeriHealth submit the medical cost data (hospital, primary care, specialty care, other medical costs and services, medical benefit drugs) under D2 on behalf of AmeriHealth customers? Is this data at the aggregate level or customer level?
A: Yes. Data will be submitted at the aggregate level, as required by the CAA.

Q: How will AmeriHealth ensure compliance with 26 CFR 54.9825-5T(b)(2)(i), 29 CFR 2590.725-3(b)(2)(i), and 45 CFR 149.730(b)(2)(i), which requires that the data submitted in files D1 and D3 – D8 must not be aggregated at a less granular level than the aggregation level used by the reporting entity that submitted the data in file D2 Spending by Category. Will AmeriHealth coordinate with the plan sponsor?
Note: The regulations acknowledge that the Departments may provide relief; Section 3.3 of the 6/29/2022 CMS manual seems to imply that CMS will check for duplication and will use the P2 file to streamline the reconciliation process. What is the AmeriHealth position on this requirement?
A: All files generated by AmeriHealth or Optum Rx will be on the same aggregation level.

Q: Will AmeriHealth submit aggregate data on an employers' behalf?
A: Yes.

Q: Where does Optum Rx stand with this new Prescription Drug Cost Reporting (RxDC Reporting) due 12/27/2022?
A: Optum Rx will create the report files, specific to Rx cost (D3 – D8). They will provide the files to AmeriHealth, along with the content for Narrative Response file. AmeriHealth will submit all files to CMS

Q: [Updated as of 10/11/23] **With regard to D1, will AmeriHealth obtain that information from the plan sponsor and file the entire report, or does AmeriHealth require the plan sponsor file the form with the government? If AmeriHealth is collecting the information from the plan sponsor, what is the AmeriHealth process for obtaining that information?**
A: AmeriHealth will produce and submit the D1 file, as a service to our self-funded customers, based on the data AmeriHealth currently has within its systems for the timeframes required for the reports.

For the June 1, 2024, and subsequent Section 204 – RxDC submission to CMS, AmeriHealth will collect information for Form 5500 Plan Code, the employee contribution information, and the PBM name through the Employer Portal.

Q: [Updated as of 10/11/23] **Can AmeriHealth confirm that the Form 5500 Plan code is needed for the current reporting? If so, what is the due date for sending this information to AmeriHealth? Also, how should the information be sent – via email, or another method?**
A: Form 5500 Plan Code will be collected using the Employer Portal. The due date to submit the information is early 2024. Due dates for subsequent submissions will be published in early in each reporting year.

Q: How will AmeriHealth handle situations where AmeriHealth doesn't have all the data necessary to complete a given data file? For example, if behavioral health claims are carved-out to a different vendor, will AmeriHealth collect the applicable data from that vendor to include in D2 (Spending by Category)?
A: AmeriHealth will create reports based on CAA requirements for all products managed by AmeriHealth, using information currently available in its source systems.

Q: For report D5 (Top 50 Drugs by Spending Increase), how will AmeriHealth determine the spending increase if AmeriHealth was not the PBM in the reference year and the year prior to the reference year?
A: The spending increase is reported on the aggregate level, not for a specific customer. Information available for all customers that were active during the reference year and prior year will be used. If

AmeriHealth prescription drug benefit is not the PBM for the customer in the reference year, the customer information will not be included in the aggregate file.

Q: [Updated as of 10/11/23] **Will AmeriHealth submit plan-specific data for customers?**
A: AmeriHealth will not submit plan-specific data for any customer in Data files (D1 – D8).

Q: In what situations would AmeriHealth recommend sending the data to the plan sponsor rather than submitting data on the plan sponsor's behalf?
A: AmeriHealth will send the data to CMS. Data will not be sent to the plan sponsor.

Q: Will AmeriHealth provide narrative responses for the following:

- **Net payments from federal or state reinsurance or cost-sharing reduction programs**
- **Drugs missing from the CMS crosswalk**
- **Medical benefit drug allocation methods**
- **Prescription drug rebate descriptions**
- **Allocation methods for prescription drug rebates**
- **Impact of prescription drug rebates on plan costs**

A: Narrative responses will include information specific to the outcome of collected data, as required by CMS. If the narrative responses apply, AmeriHealth will include the information.

Q: If AmeriHealth will provide narrative responses for one or more of the above areas, does AmeriHealth require any information from the employer to prepare any of the narrative responses?
A: Narrative responses will include information specific to the outcome of collected data, as required by CMS. At this point AmeriHealth does not anticipate obtaining any information from employers.

Q: Will AmeriHealth allow customers to choose the level of RxDC reporting support?
A: No. AmeriHealth is not offering the flexibility in the level of RxDC reporting to the customers.

Q: If AmeriHealth provides carrier/PBM credits, is AmeriHealth permitting those carrier/PBM credits to offset fees related to RxDC reporting and other CAA support activities?
A: AmeriHealth does not anticipate additional costs for the reporting service.

Q: Will AmeriHealth be able to combine data with specialty vendors and/or stop-loss carriers?
A: No, AmeriHealth will not accept data from other vendors and combine it into reporting.

Q: Will AmeriHealth provide data prepared in plan-level format that the customer must combine with specialty vendors and/or stop-loss carriers for the employer to submit?
A: No.

Q: Will AmeriHealth be able to combine data from other TPAs/PBMs that offer coverage within a customer's plan?
A: No.

Q: Will AmeriHealth provide data prepared in plan-level format that the customer must combine with other TPAs/PBMs that offer coverage within a customer's plan for the customer to submit?
A: No.

Q: If customers do not use the AmeriHealth PBM, what reports will AmeriHealth be submitting? What information will AmeriHealth require from the plan?

A: For customers who do not use AmeriHealth prescription drug benefit, AmeriHealth will submit P2, D1 and D2 reports. If customers provide their PBM Name and EIN through the Employer Portal, it will be included in the P2 report.

Q: In which circumstances will AmeriHealth not submit data and which data will AmeriHealth not submit?
A: AmeriHealth will create reports based on CAA requirements for all products managed by AmeriHealth, using information currently available in our source systems.

If customers do not use AmeriHealth prescription drug benefit, only medical cost reports (D1-D2) will be submitted. Customers with pharmacy coverage not managed by AmeriHealth will not be included in D3-D8 files.

Q: If a customer was not using the AmeriHealth services for both years 2020 and 2021, will AmeriHealth still submit data as above for the year in which it used your services? If not, please explain how AmeriHealth will support the customer.
A: AmeriHealth will include any customer that was active during any part of the reported reference year.

Q: How will AmeriHealth handle data submissions if AmeriHealth was only contracted with the plan sponsor for part of the year? For example, a customer with a non-calendar plan year may switch TPA or PBM mid-year.
A: AmeriHealth will include all available information for the customer that was active during any part of the reported reference year.

Q: What is the process and timing AmeriHealth is using to notify customers about their options?
A: Customers are not required to provide any decisions to AmeriHealth for the RxDC submission.

Q: How will AmeriHealth communicate to customers when the RxDC submission is completed?
A: AmeriHealth does not plan to inform, the plan sponsor that the data was submitted.

Q: Will employers have the ability to verify submissions when AmeriHealth submits on their behalf?
A: According to CMS, there is no mechanism to verify submissions by other parties.

Q: Will customers have access to a copy of the RxDC submission?
A: No.

Q: How long will AmeriHealth retain the RxDC submission?
A: AmeriHealth will follow its standard policy for data retention of CMS reporting.

Q: Will AmeriHealth make available the RxDC submission in the event of audit, investigation or other request as required by law?
A: Currently there are no audit requirements for RxDC submissions. AmeriHealth will address audit requests according to the law, if/when these updates are published.

Q: For former customers/plan sponsors that are no longer contracted with AmeriHealth services, what program options does AmeriHealth support for CAA reporting requirements?
A: AmeriHealth will include all available information for customers who were active during any part of the reported reference year.

Q: Who should the customer contact to engage support for historical records support? (i.e., former account team, carrier/PBM mailbox, etc.)
A: AmeriHealth does not anticipate the need for the customers to reach out, but in case there are any questions, customers can reach out to their former account team.

Q: [Updated as of 10/11/23] **For Customers who are supported by AmeriHealth PBM services through a TPA, what program options does AmeriHealth PBM support for CAA reporting requirements?**
A: AmeriHealth will submit required reporting based on CMS published due dates. AmeriHealth will include all required data elements for all customers in medical and pharmacy benefits and cost reporting. Only data for products managed by AmeriHealth, using information currently available in its source systems, will be included in the reporting. Data for carve-out products will not be included in the reporting. There is no customization or additional fees.

For the June 1, 2024, and subsequent Section 204 – RxDC submission to CMS, AmeriHealth will collect information for Form 5500 Plan Code, the employee contribution information, and the PBM name through the Employer Portal.

Q: For insured clients, do you have proposed contract language that obligates AmeriHealth to submit required files on behalf of the employer?
A: An amendment to the AmeriHealth medical insured agreements is not necessary because the agreements include a provision that requires compliance with applicable law.

Q: [Updated as of 10/11/23] **For the June 1, 2024 filing deadline, is AmeriHealth reporting and filing at aggregate level or will AmeriHealth be using customer specific info?**
A: AmeriHealth is reporting and filing at the aggregate by CMS aggregation rules – Issuer or TPA/State/Market Segment.

Q: [Updated as of 10/11/23] **When will the form be live on the Portal?**
A: The form will be live in early 2024.

Q: [Updated as of 10/11/23] **When are the form submissions due for the June 1, 2024 filing deadline?**
A: The form submissions will be due in early 2024. The deadlines for subsequent submissions will be published early in each reporting year.

Q: [Updated as of 10/11/23] **How can a terminated customer submit their information for the June 1, 2024 filing for reference year 2023?**
A: Termed customers will have access to the portal for 6 months after they have termed. Anyone who has access to the customer's account (i.e., customer, broker, sales rep), can provide the information.

Q: Do customers have to report the HMO/DPOS/POS contributions separately from the PPO contributions?
A: Yes, the reports are aggregated at the reporting company level, so AmeriHealth will need PPO and HMO/POS/DPOS total employee contribution reported separately.

Q: For insured groups, does AmeriHealth need to know the employer contributions and cost for the reference year?
A: Yes. The employee contribution is required from all customers. The employer contribution will be calculated based on the total premium or premium equivalent and employee contribution.

Q: [Updated as of 10/11/23] **If a customer does not have the AmeriHealth Rx, do they have to confirm the employee contribution for the June 1, 2024 filing?**
A: The employee contribution is required from all clients, regardless of which PBM provides Rx coverage.

Q: [Updated as of 10/11/23] **Will there be an alternative way to have customers complete the required information for the June 1, 2024 reporting deadline if they don't have portal access? What will happen if they don't provide the information or can't get access to the portal?**
A: Yes, brokers will be able to submit the information on behalf of customers, if needed. If information is not provided, it will not be included in the reports to CMS.

Q: [Updated as of 10/11/23] **What information is being collected for the June 1, 2024 filing deadline?**
A: Form 5500 Plan Number (if applicable), carved out PBM Name and EIN (if applicable), and total employee contribution amount.

Gag Clause

Q: [New as of 10/11/23] **Will AmeriHealth be submitting the attestation for termed customers?**
A: AmeriHealth will not be sending out Gag Clause Attestations on behalf of customers that are not active in December 2023 or in December of future Attestation years.

Q: [Updated as of 10/11/23] **Does the current AmeriHealth contract have a Gag clause prohibiting the disclosure of provider-specific cost or quality information to referring providers, us as the plan sponsor or members/individuals eligible to become members?**
A: Contracts with providers do not contain any Gag Clauses that prohibit disclosure.

Q: Will AmeriHealth submit the attestation for insured customers or are the customers responsible for submission?
A: Yes, AmeriHealth will submit the attestation for insured customers by the required date from CMS. Additional details will be published at the future date.

Q: Will AmeriHealth be assisting plan sponsors with the attestation pertaining to gag clauses due to the federal government by December 31, 2023?
A: AmeriHealth will submit the attestation on customer's behalf. Data will not be provided to the customers directly. The administrative services agreements with self-funded groups will be amended to include a provision in which the self-funded group authorizes AmeriHealth to submit the attestation on behalf of the plan sponsor.

Q: How will AmeriHealth certify to its customers that its contracts are free of all gag clauses?
A: AmeriHealth will submit the attestation on customer behalf; data will not be provided to the customers directly. AmeriHealth will post a Market Edge article notifying the customers that the attestation was completed.

Provider Contracts

Q: Is AmeriHealth prepared to report compliance with the new requirements that group health plans cannot enter into a services agreement that, directly or indirectly, restricts the group health plan from disclosing provider-specific costs, quality of care information, or electronically accessing de-identified claims data?
A: Yes.

Q: What is expected timing in accordance with the new regulations?
A: The AmeriHealth Provider Communications team published Advisory and Amendment language in May 2021 describing compliance with the provision and an amendment notice for any legacy contracts.

Q: How will insights on market pricing affect provider contract negotiation strategies?
A: There may be providers who attempt to take advantage of the public data and compare this to their reimbursement; however, AmeriHealth is prepared to enter each negotiation with discussion items that are only relevant to that provider.

Q: What are the implications of transparency requirements for value-based care arrangements (compared to fee-for-service)?
A: AmeriHealth does not foresee any implications as the fee-for-service rates are the rates that are required to be published.

General Questions

Q: Please describe how AmeriHealth is coordinating the cross-functional, enterprise-wide implementation of the CAA and TCR requirements.
A: AmeriHealth established an enterprise-wide implementation program to ensure all requirements are implemented by the compliance dates. The requirements for implementing the CAA and TCR are evolving, and AmeriHealth is committed to meeting the requirements by the compliance dates.

Q: Will AmeriHealth post notice of the NSA requirements and include such notice in all EOBs for affected items and services?

A: Yes. The notice is included in the EOB. AmeriHealth is creating a public webpage on amerihealth.com in which detailed information will be published as required. AmeriHealth continues to work through its member communication strategy, including notifying members where this information will be shared.

Q: How and when will updates on the AmeriHealth compliance with the various requirements of the CAA and TCR be disseminated to customers?
A: AmeriHealth will comply with the laws by the compliance dates. As is AmeriHealth standard practice, AmeriHealth will share information about its compliance and outreach via *Market Edge* communications. AmeriHealth will be communicating with members directly for its customers.

Q: How will AmeriHealth use price transparency as an opportunity to improve the member experience?
A: AmeriHealth will promote and use price transparency to help members better understand their benefits and cost-sharing.

Q: Will AmeriHealth support group customers' communication to their employees on these changes and new resources?
A: As things continue to evolve, AmeriHealth will communicate our approach and keep members and other stakeholders informed of any changes.

Q: List any third-party vendors or subcontractors AmeriHealth plans to use to support group health plans in complying with the requirements of the CAA and TCR.
A: The following vendors are involved:

- enGen: the AmeriHealth platform vendor

- HealthSparq (now owned by Kyruus): the AmeriHealth transparency tool vendor

Q: How will AmeriHealth use price transparency as an opportunity to improve the member experience?

A: AmeriHealth will promote and use price transparency to help members better understand their benefits and cost-sharing.

Transparency in Coverage Final Rule (TCR)

On November 12, 2020, the Departments of Labor (DOL), Health and Human Services (HHS), and Treasury (collectively, the Departments) published the "Transparency in Coverage" final rule, imposing new requirements on group health plans and health insurers in the individual and group markets to disclose cost-sharing information, in-network provider negotiated rates, historical out-of-network allowed amounts, and drug pricing information. It also applies to Qualified Health Plan (QHP) issuers and the Federal Employees Health Benefits Program. 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.

TCR does not apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision- or dental-only plans. Nor does it apply to grandfathered health plans; account-based group health plans, such as HRAs, including individual-coverage HRAs; or health FSAs, healthcare-sharing ministries, or short-term limited duration insurance plans.

TCR's core requirements are to:

- Disclose to the public: 1) in-network provider negotiated rates, 2) historical out-of-network allowed amounts, and 3) drug pricing information, which has been postponed, pending further rulemaking, through three separate machine-readable files posted on an internet website; and
- 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 if requested.

TCR adopts a three-year, phased-in approach for compliance, which requires Plans and Issuers to provide:

- Public access to in-network provider negotiated rates and historical out-of-network allowed amounts for plan years that begin on or after July 1, 2022;
- Cost-sharing information to participants, beneficiaries, or enrollees for all covered items and services for plan years that begin on or after January 1, 2024; and
- Pending further rulemaking, public access to drug pricing information.

TCR also allows health insurance issuers to receive credit in their Medical Loss Ratio calculations for programs that create shared-savings for members resulting from their shopping for, and receiving care from lower-cost, higher-value providers.

Resources

CMS Transparency in Coverage Fact Sheet

Transparency in Coverage Final Rule (TCR)

Q: Does the Transparency in Coverage rule apply to insurers and group health plans?

A: Yes, TCR applies to health insurers and group health plans. AmeriHealth is responsible for implementing the requirements for insured group health plans.

Machine-Readable Files

Q: What are the requirements for July 1, 2022?

A: Enforcement for Machine Readable Files (MRFs) was delayed from January 1, 2022, to July 1, 2022, for negotiated in-network rates as well as out-of-network allowed amounts and billed charges. Enforcement for prescription drug costs (negotiated rates and historical net pricing) was deferred pending additional rulemaking.

Q: What does it mean for you as the employer?

A: As an employer, it is important to be mindful of the appropriate ways to leverage and consume this newly available data, ensuring that you do not draw false conclusions through an "apples to oranges" comparison.

Additionally, with the availability of this MRF data, new market entrants may seek to sell products and solutions leveraging this data, with promises of a new, more accurate carrier comparison tool. While over time this data could yield meaningful new insights, particularly in the short term we believe that leveraging consultant analyses based on the Uniform Discount and Data Specifications (UDS) process will provide the most accurate carrier cost comparisons. UDS is a transparent and consistent industry specification for how carriers submit their data to national consulting firms for both Discount and Total Cost of Care analyses, and the approach has been fine-tuned over the course of the last 15 years. Many consulting firms utilize this data to compare cost positions across carriers to help employers make sound financial decisions.

While this data may pose challenges in carrier cost comparisons, there is ample opportunity for employers to leverage this data to support consumerism within their populations. When used in conjunction with the transparency tools offered by AmeriHealth, members will receive insights as to the cost of services for a specified provider before care is rendered, helping them to select lower cost providers and reducing cost for both the employer and the member in the long term.

Q: What are some complexities that require an element of interpretation with these MRFs?

A: As an example of the complexity in comparing costs across carriers, consider the following example: Carrier A pays the provider for the entire emergency room visit (doctor visit, labs, x-ray etc.) using a single bundled payment, while Carrier B pays each component separately. This difference in reimbursement structure would not be readily apparent in the MRFs and could lead to inaccurate conclusions regarding Carrier A and Carrier B's relative cost.

Q: What format should the data be displayed according to the requirements? Indicate which file format AmeriHealth will utilize.

A: Data files must be displayed in a standardized format and must be updated monthly. AmeriHealth will be posting the data as a .JSON file. For insured customers, the name of the MRF Index will follow this format: **yyyy-mm-dd_ahnj_index.json** (for AmeriHealth NJ Insurance Co, Inc.) or **yyyy-mm-dd_ahnjhmo_index.json** (for AmeriHealth HMO, Inc.).

Q: What is a "JSON" file?

A: The JSON (JavaScript Object Notation) format is a technical standard data interchange format. It is primarily used for transmitting data between a web application and a server. These files must be opened using a specialized JSON file reader. If a JSON file, which has a .JSON file extension, is opened using a standard business application (such as Microsoft Word), the file contents will appear as a large series of alpha numeric characters that will not be able to be clearly read or understood. If opened by a non-JSON file reader, the file may look similar to the graphic below. For more information, visit https://www.cms.gov/healthplan-price-transparency.

Example JSON format:

Q: Who are the intended audiences for MRFs?

A: The files are expected to be used by researchers, government entities and data aggregators to develop comparative data across health insurance issuers. While made available to the general public as required by regulation, the MRFs are not intended for use by members or customer non-technical business users.

Q: When will the files be updated each month? (e.g. by the 15th of every month, 2nd Tuesday of the month).

A: The files will be updated by the 10th of every month.

Q: Will the files include plan-specific information (e.g., ERISA plan name, number, sponsor EIN) as required by the regulations?

A: No, regulations do not require insured client identifiers.

Q: Will AmeriHealth combine multiple applicable networks for in-network files if the plan uses different networks in different locations? Will AmeriHealth combine multiple applicable networks for in-network files if the plan offers multiple networks for different plan options?

A: AmeriHealth is adding links to the table of contents for 2 rental networks (Multiplan PHCS and GHI-Emblem).

Q: Do you have any sample files available, and if so, could you provide?

A: No, sample files are not available.

Q: Will files be validated using the CMS schema validator prior to posting? (https://github.com/CMSgov/price-transparency-guide-validator)

A: Yes.

Q: Describe the quality assurance process that will be in place to ensure accuracy of rates provided in the MRFs.

A: AmeriHealth has two stages of testing, system testing and user acceptance testing. As part of the system testing, the testing team will test the layout of the files as well as data validation. The user acceptance testing will include multiple business areas reviewing and testing the data as needed.

Q: Will there be any additional fees associated with the Machine-Readable Files?
A: There will be no additional fees for the standard files.

Q: Do you have tech support in the case that there are issues with missing files, website downtime, etc.? How can we get in touch?
A: Customers will contact their Account Management team with any issues experiences. The Account Management team will work with teams internally to get the issue resolved.

Q: Please confirm if the files will be posted to the AmeriHealth website. If not yet available, please confirm where and when it will be posted.
A: Insured customers will be directed to https://www.amerihealth.com/developer-resources/index.html where they can find the MRFs for AmeriHealth Insurance Company of New Jersey. and AmeriHealth HMO, Inc. The name of the MRF Table of Contents will follow this format: **yyyy-mm-dd_ah_index.json** (for AmeriHealth Insurance Company of New Jersey) or **yyyy-mm-dd_ahhmo_index.json** (for AmeriHealth HMO, Inc.) per CMS requirements and provide an index of MRF links for AmeriHealth Insurance Company of New Jersey and AmeriHealth HMO, Inc.

Q: Will the files satisfy all technical specifications as described on github.com?
A: The files will comply with all required specifications per the CMS GitHub site.

Q: Will the link to the MRFs change each month or will the link stay the same? If they are changing, how will the new links be provided each month?
A: The link will stay the same.

Q: Does anyone wanting to access the machine-readable file have to open a user account?
A: MRFs will be publicly available to all users. Account logins and passwords will not be required.

Q: In addition to creating and hosting the Machine-Readable files, will AmeriHealth retain historical copies of the Machine-Readable Files to help customers satisfy ERISA's record retention requirements?
A: AmeriHealth will store and retain the MRFs data for 10 years at no cost to our customers.

Q: Please delineate the impact, if any, on the administrative fees (or premiums for insured plans) as a result of these changes.
A: There will be no impact to premiums.

Q: Will AmeriHealth incorporate external data (e.g., PBM, specialty network, etc.)?
A: Yes. AmeriHealth will incorporate data from the AmeriHealth preferred vendor partners as well as incorporate the rental network rates into the in-network files.

Q: How will the requirements outlined in the TCR impact contracts with groups? Which provisions from the TCR will be addressed in plan-sponsor contracts?
A: The AmeriHealth agreements already state that AmeriHealth will comply with all applicable laws.

Q: This will be required for prescription drugs that run through the medical plan. Do you foresee any issues?
A: At this point, AmeriHealth does not anticipate any issues with including prescription drugs administered through the medical plan. Medical drug rates will be included in the in-network rate file. Out-of-network medical drug allowed amounts will be included in the allowed amount file. Prescription

drug rates would be included in the third machine readable file once additional guidance is received from the federal government.

Q: Once additional guidance is released on the prescription drug file, will this file be prepared for prescription drugs that go through the medical plan?
A: If the Tri-Agencies mandate the prescription drug file, only Pharmacy rates will be present on the Rx file. Medical drug rates will be available through the In Network Rate file.

Q: How will AmeriHealth respond to questions regarding any missing values such as NPI, procedure codes, etc.?
A: AmeriHealth would not be compliant if required data is missing. AmeriHealth will update data as needed and will develop a process to respond to inquiries regarding the files.

Miscellaneous Questions

Q: Please share how AmeriHealth intends to comply with the Secretary of Labor's standardized reporting format for voluntary reporting to State All Payer Claims Databases.
A: AmeriHealth will comply with all mandatory requirements of the CAA and Transparency in Coverage Federal Rule. Reporting to a State All Payer Claims Database is voluntary and not mandated.

Q: Who has primary accountability at AmeriHealth to ensure the TCR and CAA requirements are met (title not name)?
A: Senior Vice President, Marketing and Sr. Vice President, Operations.

Q: What is the process and cadence for reporting progress to senior leadership within AmeriHealth (e.g., quarterly report outs to CEO, Board of Directors, etc.)?
A: AmeriHealth distributes weekly project status reports and has monthly meetings with Senior Leadership.

Q: Does AmeriHealth have an active risk mitigation strategy in place if the TCR and CAA requirements are not met? If not, what is the timeline for implementation of said strategy?
A: AmeriHealth is actively identifying, evaluating, and managing risks with these initiatives.

Q: What is the AmeriHealth communication plan for those not digitally engaged when trying to send updates about the new regulations?
A: AmeriHealth is actively developing a communication strategy for all members. Members who are not digitally engaged will be able to call the Customer Service number for any questions about their plan and benefits. Additionally, AmeriHealth posts detailed information on the AmeriHealth corporate website.

Q: As a service provider, is AmeriHealth providing any brokerage or consulting services as defined by the statute?
A: No.