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 Administrators further sharpens efforts on transparency

AmeriHealth Administrators 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 Administrators understands that the federal government will be issuing additional guidance. The guidance issued by the federal government will impact AmeriHealth Administrators implementation of the CAA and TCR.

AmeriHealth Administrators has an enterprise-wide implementation program in accordance with the requirements of the CAA and TCR applicable to them.

AmeriHealth Administrators will continue to update these FAQs as AmeriHealth Administrators receive additional guidance and updated FAQs will be communicated via the *Market Edge* newsletter. AmeriHealth Administrators is committed to implementing the requirement of the CAA and TCR applicable to them.

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AmeriHealth Administrators

Updated: October 11, 2023

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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 Administrators be in compliance with the CAA by 1/1/2022?
A: AmeriHealth Administrators is committed to meeting the requirements of the CAA applicable them.

Q: [Updated as of 10/11/23] **How will the requirements outlined in the CAA impact contracts with groups? Which provisions from the CAA will be addressed in contracts with group health plans?**
A: AmeriHealth Administrators agreements with insured or self-funded groups require that AmeriHealth Administrators must comply with all applicable laws. The CAA will not materially change AmeriHealth Administrators administrative services agreements, although for self-funded health benefits plans, the CAA imposes certain requirements on the plan sponsor/plan fiduciary. However, AmeriHealth Administrators will be amending the agreements with self-funded groups to include descriptions of the administrative services AmeriHealth Administrators is providing related to certain provisions of the CAA.

Advanced EOB (AEOB)

Q: What are AmeriHealth Administrators plans for accommodating the CAA requirement to provide AEOBs to members in 2022?
A: For participating providers, AmeriHealth Administrators 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: Yes, AmeriHealth Administrators will comply with the law.

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

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

Q: Will AmeriHealth Administrators incorporate data from carve-out vendors, such as pharmacy benefit managers into AEOBs?
A: Among other requirements of the AEOB, AmeriHealth Administrators is required to provide a good faith estimate of the member's requested items or services according to their coverage. AmeriHealth Administrators will comply with the requirements for the benefits administered by AmeriHealth Administrators. AmeriHealth Administrators is only incorporating its data and the data of AmeriHealth Administrators preferred vendors, which does not include non-preferred pharmacy benefit managers. If a group offers benefits outside of AmeriHealth Administrators, they should work directly with their vendors.

Q: Will AmeriHealth Administrators share data with third parties, such as Castlight and Healthcare Bluebook, to enable the production of AEOBs?

A: Pending further guidance from the federal government, AmeriHealth Administrators is focusing on implementing the AEOB requirement. Customer requests will be addressed as customizations.

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

Q: Will AmeriHealth Administrators make an internet-based self-service price comparison tool available to members for the initial 500 "shoppable" services for both self-funded 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 unless a self-funded customer is provided transparency services through a separate entity or vendor.

Q: Will the tool be offered at no added cost to the plan sponsor or members?
A: Yes. However, customizations and integrations will be considered on a case-by-case basis if requested by a self-funded customer and may have additional cost.

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 ahatpa.com and the AmeriHealth Administrators mobile app. AmeriHealth Administrators 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 Administrators will 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: AmeriHealth Administrators 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: AmeriHealth Administrators tool will provide all required functionality.

Q: Will AmeriHealth Administrators 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 Administrators will provide a standard implementation, as required. AmeriHealth Administrators believes its current tool is already compliant for the majority of AmeriHealth Administrators 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 Administrators 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 Administrators provide the price comparison in paper form upon request without an added fee?
A: Yes.

Q: Will AmeriHealth Administrators 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 Administrators will comply with the requirements of the law.

Q: As the final rule allows AmeriHealth Administrators to limit the price comparison printed paper request to 20 providers, will AmeriHealth Administrators 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 Administrators will identify a service or item where the member's plan 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 Administrators tool will display required pre-requisites and disclaimers.

Q: Will AmeriHealth Administrators 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 Administrators tool will display required messaging concerning OON services and costs.

Q: For self-funded customers, will AmeriHealth Administrators amend the Administrative Services Agreement (ASA) to serve as written agreement that AmeriHealth Administrators will assume this compliance responsibility?
A: No. AmeriHealth Administrators ASAs with self-funded customers include compliance with law provisions that require that both AmeriHealth Administrators and the self-funded customer comply with all applicable law. Applicable law includes the CAA and the transparency rule. Therefore, the ASA does not have to be amended.

ID Cards

Q: Will AmeriHealth Administrators 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 Administrators does not anticipate any file changes or interfaces will be needed. There will be a modification to the existing file sent to AmeriHealth Administrators ID card vendor.

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

Q: What is the process to ensure continuity of care?

A: AmeriHealth Administrators current continuity of care policy is compliant with the requirements of the CAA. AmeriHealth Administrators 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: Members will receive a letter when a contracted provider leaves the network. Members with a Continuity of Care issue are directed to call Customer Experience

Q: Will AmeriHealth Administrators identify individuals that qualify as "continuing care" and send them any required notices?
A: AmeriHealth Administrators will notify members when a contracted provider leaves the network. Members with a Continuity of Care issue are directed to call Customer Experience. Clinical Services will review members for continuity of care and the claims system will be updated to review claims for those members and adjudicate accordingly.

Q: Will AmeriHealth Administrators 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: AmeriHealth Administrators current continuity of care policy is compliant with the CAA. Up to 90 calendar days of continuity of care will be 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 plan. Continuity of care determinations are made based on medical necessity.

Provider Directories

Q: Will AmeriHealth Administrators be in compliance by the effective date?
A: AmeriHealth Administrators is committed to meeting the requirements applicable to them.

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

Q: Are there additional fees?
A: There are no additional fees for Provider Directory

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 Administrators 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 Administrators has an existing process performed by Customer Service to make sure 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 Administrators notify employers of directory updates?
A: No, AmeriHealth Administrators 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 data feeds to employer hosted websites.

Q: How will access to the directory be provided (i.e., directly or via an employer website)?
A: AmeriHealth Administrators provider directory is available on AmeriHealth Administrators 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 Administrators will administer the claim at the in-network level?
A: AmeriHealth Administrators 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 AmeriHealth Administrators online provider directories comply with the requirements of the CAA?
A: Yes.

Q: Describe the process by which the accuracy of AmeriHealth Administrators 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 Administrators be in compliance with the new disclosure requirements related to broker compensation by the effective date?
A: AmeriHealth Administrators is currently in compliance as all broker-related fees are between the broker and plan fiduciary.

Surprise Billing

Q: The CAA requires health plans to reimburse out-of-network providers and facilities in the situations where balance billing is prohibited. Will you be offering services to support this?
A. AmeriHealth Administrators changed its claims processing to recognize the specific claim types based on the definitions set forth in the CAA Out-of-network providers will be reimbursed following the regulations within the CAA.

Q: Will AmeriHealth Administrators partially or fully reimburse member balance billing if a group health plan wants to extend balance billing protection beyond those services subject to the CAA's protections? Describe available options.
A: AmeriHealth Administrators adjudicates claims based on the direction of the plan sponsor. Changes from the plan sponsor outside of the CAA would need to be evaluated for implementation.

Q: Describe any services in support of compliance with CAA surprise billing protections that will be subcontracted or outsourced to third parties. List the name of each party and services provided by each.
A: AmeriHealth Administrators is not using a subcontractor for CAA Surprise Billing.

Q: What should a member do if they receive a surprise medical bill that is otherwise prohibited under the new regulations?
A: Your Rights and Protections Against Surprise Medical Bills is available on https://www.ahatpa.com/html/privacy/index.html. Members may also call the customer service number on their ID card and may submit an appeal for the surprise medical bill which is also available for External Review

Q: Please confirm balance billing will be prohibited for air ambulance.
A: The air ambulance claims will be processed according to the requirements of the CAA.

Q: For an air ambulance provided by a nonparticipating provider, please confirm AmeriHealth Administrators will determine the cost-sharing on the lesser of the qualifying payment amount ("QPA") or the billed amount.
A: The payment for air ambulance services is based on the requirements of the CAA.

Q: Describe the steps AmeriHealth Administrators 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 Administrators made certain revisions to the 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 Administrators has developed a communication plan to inform customers 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 Administrators confirm the amount that AmeriHealth Administrators is using for the initial payment to the OON providers? Is AmeriHealth Administrators using the Qualifying Payment Amount or the allowable charge?
A: The QPA methodology used by AmeriHealth Administrators complies with the requirements of the CAA.

Q: As related to AmeriHealth Administrators 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 Administrators is not planning any changes to the surprise billing protections other than changes required by the CAA.

Q: Will AmeriHealth Administrators 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 Administrators 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 Administrators has developed a communication plan to inform customers and providers about the No Surprises provision of the CAA.

Q: For coverage of non-emergency services provided by nonparticipating providers at a participating facility, please confirm the member will pay the in-network cost-share and the cost-share will count toward the in-network and out-of-network deductibles (if applicable).
A: Yes, AmeriHealth Administrators will process the claims based on the requirements of the CAA.

Q: Please confirm the definition of "visit" and "facilities" for emergency services and nonemergency services by nonparticipating providers in participating facilities will be administered according to the IFR definitions.
A: The IFR definitions of "visit" and "facilities" will comply with the CAA.

Q: Please confirm AmeriHealth Administrators will be calculating the "recognized amount" to determine the cost-sharing for emergency services furnished by a nonparticipating emergency facility, and for non-emergency services furnished by nonparticipating providers in a participating health care facility.
A: AmeriHealth Administrators will calculate the recognized amount based on the requirements of the CAA.

Q: Please confirm if AmeriHealth Administrators will be supporting the disclosure requirement as outlined by the IFR. Specifically, please confirm that AmeriHealth Administrators will make publicly available, post on a public website of the plan or issuer and include on each explanation of benefits for an item or service with respect to which the surprise medical billing requirements apply.
A: AmeriHealth Administrators is complying with the CAA by publishing disclosures with required language on AmeriHealth Administrators public sites and in the member EOBs for claims subject to the CAA.

Q: How will AmeriHealth Administrators notify members of its Public Disclosure files on its website?
A: AmeriHealth Administrators has posted the disclosures on its website. as required.

Q: Will AmeriHealth Administrators be in compliance by the effective date?
A: Yes.

Q: Will groups be notified of appeals by the provider?
A: AmeriHealth Administrators will not notify the customers in the event of provider-requested negotiations. In the event a negotiation is successful, and provider agrees to a proposed payment, then the claim will be adjusted to the agreed upon amount.

Q: How will shared savings arrangements be impacted by the Surprise Billing requirements?
A: Shared savings arrangements are implemented with participating providers, and there is specific language that prohibits surprise billing in the provider contracts.

Q: Please explain the impact, if any, on the administrative fees as a result of these changes.
A: There will be no impact to administrative fees, but any custom requests may incur fees.

Independent Dispute Resolution (IDR)

Q: What is the process for IDR?
A: AmeriHealth Administrators will participate in Independent Dispute Resolution (IDR) per the CAA when initial negotiation between AmeriHealth Administrators and the provider fails, and upon a provider's request. IDR will be administered by CMS-approved IDR entities through the CMS Portal. AmeriHealth Administrators will use the CMS-published process for communication with CMS, the providers, and Certified IDR Entities.

Q: Which entities will fulfill the role of IDR? Is this different from the entity that AmeriHealth Administrators currently contracts with to negotiate disputed claims?
A: CMS has published a list of approved entities which can be found at https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list. CMS is expected to update the list with additional entities, as they become certified. For external reviews, AmeriHealth Administrators contracts with several Independent Review Organizations (IROs) which are not the same as the Independent Dispute Resolution (IDR) entities.

Q: How will AmeriHealth Administrators ensure members are protected from balance bills where legislation requires that protection? Specifically, when plan members encounter these situations: Seek out-of-network emergency care

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

A: AmeriHealth Administrators has changed its claims processing to recognize the specific claim types based on the above categories of claims and these claims will process according to the CAA. Members and providers will also be informed that the claims are subject to the CAA, and balance billing is prohibited.

Q: [Updated as of 10/11/23] **Can you confirm whether AmeriHealth Administrators will be supporting self-funded customers with the IDR process, and whether there is a cost?**
A: AmeriHealth Administrators will negotiate claims disputed through the IDR process on behalf of the group. These negotiations may include communicating with the provider and group about disputed claims, as well as proposing and documenting the resolution of disputed claims. If disputed claims escalate to IDR, AmeriHealth Administrators will handle interactions with the IDR entity and provider. Fees and costs may be charged back to the group.

Q: For claims undergoing IDR, will AmeriHealth Administrators make the following payments on behalf of the plan sponsor:

- **Administrative fee payable to the certified IDR entity**
- **Cost of IDR process when plan sponsor is determined to be the non-prevailing (losing) party**

A: Subject to federal government guidance, AmeriHealth Administrators intends to negotiate with the provider and respond to provider-initiated IDR on the customer's behalf, including all fees and costs required by the IDR process. The self-funded customer will be responsible for all fees and costs associated with the IDR process.

Q: Is there anything the customer needs to do to prepare for an IDR? Or should the customer anticipate this to be handled entirely by AmeriHealth Administrators?
A: No, customers do not need to do anything to prepare for an IDR. AmeriHealth Administrators will handle IDR negotiations initiated by providers on the customer's behalf.

Q: How will customers be notified that a provider is seeking payment beyond out-of-network allowable charges?
A: Customers will not be notified that a provider is seeking payment beyond out-of-network allowable charges. AmeriHealth Administrators will negotiate with the provider on the customer's behalf.

Q: What processes will be put in place so that the customer is aware of potential additional spend and when additional action may need to be taken?
A: AmeriHealth Administrators will negotiate with the provider and respond to provider-initiated IDR on the customer's behalf. Customers will not receive notification that this process is occurring. In the event IRD is decided for the provider, the claim will be adjusted to the amount identified by the IRD Entity.

Q: What are the IDR Process timelines outlined in the September 30, 2021 Rule?
A: Important Open Negotiation and Independent Dispute Resolution Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

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

Q: [Updated as of 10/11/23] **Will AmeriHealth Administrators be offering services to support the requirements for health plans to conduct comparative analyses of the nonquantitative treatment limitations (NQTLs) used for medical and surgical benefits, as compared to mental health and substance use disorder benefits?**

A: The Third-Party Administrator's self-funded customers are responsible for compliance with applicable law including mental health parity (MHP) and are responsible for the nonquantitative treatment limitations (NQTLs) assessment for their Group Health Plan(s). As a third-party administrator for the self-funded customer, AmeriHealth Administrators will assist the AmeriHealth Administrators self-funded customer's efforts to document the NQTL's by reviewing NQTLs that are not tied to specific Group Health Plan designs.

The third-party Administrator's generic analysis of the NQTLs will be provided to a self-funded customer, upon request, if the generic analysis matches the customer's Group Health Plan. Where the third-party administrator is the nominated claim fiduciary for the plan and responsible for medical management and the plan does not contract separately for behavioral health or with providers, much of the generic NQTLs prepared may be applicable to the self-funded Group Health Plan. To the extent a self-funded customer, for their self-funded Group Health Plan, has customized their Prior Authorization List or has carved out behavioral health to another third party administrator or uses a vendor for Medical Management, or any other functions or benefits to which the self-funded Group Health Plan has separate contracts with Vendors, Providers, or Facilities, or uses a PBM that is not Optum Rx, or has customized the Optum Rx Select Drug Formulary or the Premium Formulary, the self-funded customer should analyze its Group Health Plan to determine compliance with mental health parity and provide its NQTL analyses to regulators.

Q: [Updated as of 10/11/23] **Are there additional fees to perform this analysis?**
A: There will be no charge for the standard analysis, however customized analysis, if agreed to perform on customers behalf, may be subject to additional fees.

Q: [Updated as of 10/11/23] **Will you provide an analysis of all financial requirements and NQTLs applicable to the plan, in accordance with mental health parity rules? If not, can a customer request AmeriHealth Administrators support for testing?**
A: Self-funded customers are responsible for their own compliance and to conduct the NQTL analysis required by law, however AmeriHealth Administrators will assist with a customer's efforts to document the NQTLs if the generic analysis matches the customers Group Health Plan. AmeriHealth Administrators may provide courtesy testing for QTLs if the self-funded plan does not have carve out benefits or substantial customization.

Q: Will AmeriHealth Administrators confirm if it is proactively performing testing for self-funded customers?
A: AmeriHealth Administrators is not proactively preforming testing for self-funded customers. AmeriHealth Administrators may provide courtesy testing for QTLs if the self-funded plan does not have carve out benefits or substantial customization. Self-funded customers should analyze their health plans and consult their Legal counsel to determine compliance with federal mental health parity.

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 Administrators will assist the customer's efforts to document the NQTLs in response to a DOL subpoena if the generic analysis matches the customers Group Health Plan.

Q: Will you communicate to the customer sponsor about any detected MHPAEA violations and the necessary corrective actions taken to resolve the issue? How soon will the information be communicated to customer?
A: AmeriHealth Administrators will notify the customer if there is a final finding of noncompliance with MHPAEA by a regulator.

Q: What is AmeriHealth Administrators expected timing in accordance with the new requirements? What is the impact of these changes, if any, on administrative fees?
A: AmeriHealth Administrators continuously reviews and updates NQTL comparative documents. AmeriHealth Administrators does not charge for supporting DOL inquiries and DOL requests of information and NQTL documentation.

Q: [Updated as of 10/11/23] **Upon an official request from a regulator, will AmeriHealth Administrators 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: The self-funded customer is responsible for compliance with applicable law including mental health parity (MHP) and is responsible for the nonquantitative treatment limitations (NQTLs) assessment for their Group Health Plan(s). AmeriHealth Administrators will assist the self-funded customer's efforts to document the NQTL's by reviewing NQTLs that are not tied to specific Group Health Plan designs.

AmeriHealth Administrators generic analysis of the NQTLs will be provided to a self-funded customer, upon request, if the generic analysis matches the customer's Group Health Plan. Where AmeriHealth Administrators is the nominated claim fiduciary for the plan and responsible for medical management and the plan does not contract separately for behavioral health or with providers, much of the generic NQTLs prepared may be applicable to the self-funded Group Health Plan. To the extent a self-funded customer, for their self-funded Group Health Plan, has customized their Prior Authorization List or has carved out behavioral health to another third party administrator or uses a vendor for Medical Management, or any other functions or benefits to which the self-funded Group Health Plan has separate contracts with Vendors, Providers, or Facilities, or uses a PBM that is not Optum Rx, or has customized the Optum Rx Select Drug Formulary or the Premium Formulary, the self-funded customer should analyze its Group Health Plan to determine compliance with mental health parity and provide its NQTL analyses to regulators.

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

Q: [Updated as of 10/11/23] **Please confirm the customer will not be charged for this support.**
A: There will be no charge for the standard analysis however customized analysis, if agreed to perform on customers behalf, may be subject to additional fees.

Reporting Requirements

Q: [Updated as of 10/11/23] **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. Will AmeriHealth Administrators plan to produce reports for customers that meet these requirements?
A: Yes. AmeriHealth Administrators will produce and submit files P2, D1 and D2, as a service to our self-funded customers, based on the data AmeriHealth Administrators currently has within its systems for the timeframes required for the reports. If the self-funded client has Optum Rx as their PBM, Optum Rx will provide the files D3 through D8 to AmeriHealth Administrators. AmeriHealth Administrators will submit all files to CMS in one 'reporting' package. For self-funded customers with coverage through a different PBM, data for the D3 through D8 files will not be included.

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, meaning the years in which the data will be reported from). Future annual report submissions will be due by June 1st of each year **(reference year, meaning the year the data is reported from, is prior calendar year).**

Q: [Updated as of 10/11/23] **Do self-funded customers have to do anything for the submissions?**
A: For the June 1, 2024, Section 204 – RxDC submission to CMS, AmeriHealth Administrators 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 Administrators include the required data for?
A: AmeriHealth Administrators will include the required data for self-funded plans.

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

Q: Does AmeriHealth Administrators expect to be a "reporting entity" and is AmeriHealth Administrators 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 Administrators will be a "reporting entity" and will produce reports based on RxDC reporting instructions, including aggregate spending amounts based on required categories based on the data within our systems during the timeframes required for the report.

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

Q: What decisions does AmeriHealth Administrators 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 Administrators does not need a decision from customers. AmeriHealth Administrators will produce reports including the Rx data as required by CMS for self-funded customers whose PBM is Optum Rx. Self-funded customers with coverage through a different PBM should work with their PBM for reporting of the Rx data.

Q: [Updated as of 10/11/23] **If a customer sends AmeriHealth Administrators information that AmeriHealth Administrators does not have in its possession (e.g., Group Health Plan List information, average monthly employee/employer/total premium, ASO fees, etc.), will AmeriHealth Administrators be able to submit that information on the customer's behalf?**
A: For the June 1, 2024, and future yearly reports, Section 204 – RxDC submission to CMS, we will collect information for Form 5500 Plan Code, the employee contribution information, and the PBM name through the Employer Portal. No additional information will be collected or included in the submission.

Q: Assuming AmeriHealth Administrators can be a reporting entity, please describe how AmeriHealth Administrators will notify customers after submitting the reporting. The CMS instructions note that CMS will not be able to notify the plan that data has been submitted on their behalf.
A: AmeriHealth Administrators does not plan to notify its self-funded customers of the RxDC submission.

Q: What is AmeriHealth Administrators EIN?
A: AmeriHealth Administrators EIN is available by contacting your Account Rep.

Q: Will AmeriHealth Administrators 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: AmeriHealth Administrators will produce and submit files P2, D1 and D2, as a service to our self-funded customers, based on the data AmeriHealth Administrators currently has within its systems for the timeframes required for the reports. If the self-funded client has Optum Rx as their PBM, Optum Rx will provide the files D3 through D8 to AmeriHealth Administrators. AmeriHealth Administrators will submit all files to CMS in one 'reporting' package. For self-funded customers with coverage through a different PBM, data for the D3 through D8 files will not be included.

Q: Will AmeriHealth Administrators submit the medical cost data (hospital, primary care, specialty care, other medical costs and services, medical benefit drugs) under D2 on behalf of AmeriHealth Administrators 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 Administrators 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 Administrators 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 AmeriHealth Administrators position on this requirement?
A: All files generated by AmeriHealth Administrators or Optum Rx will be on the same aggregation level.

Q: Will AmeriHealth Administrators 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 Administrators, along with the content for Narrative Response file. AmeriHealth Administrators will submit all files to CMS in one 'reporting' package.

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

For the June 1, 2024, Section 204 – RxDC submission to CMS, AmeriHealth Administrators 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 Administrators 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 Administrators? 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 Administrators handle situations where AmeriHealth Administrators 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 Administrators collect the applicable data from that vendor to include in D2 (Spending by Category)?
A: AmeriHealth Administrators will produce and submit the files, based on the data we currently have within its systems for the timeframes required for the reports.

Q: For report D5 (Top 50 Drugs by Spending Increase), how will AmeriHealth Administrators determine the spending increase if AmeriHealth Administrators 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 Administrators is not PBM for the customer in reference year, customer information will not be included in the aggregate file.

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

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

Q: Will AmeriHealth Administrators provide narrative responses for the following:

- **Estimation method for calculating employer size for self-funded plans**
- **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 Administrators will include the information.

Q: If AmeriHealth Administrators will provide narrative responses for one or more of the above areas, does AmeriHealth Administrators 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 Administrators does not anticipate obtaining any information from employers.

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

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

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

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

Q: Will AmeriHealth Administrators 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: [Updated as of 10/11/23] **If customers do not use AmeriHealth Administrators PBM, what reports will AmeriHealth Administrators be submitting? What information will AmeriHealth Administrators require from the plan?**
A: For customers who do not use AmeriHealth Administrators prescription drug benefit, AmeriHealth Administrators will submit P2, D1 and D2 reports, as a service to our self-funded customers, based on the data AmeriHealth Administrators currently has within its systems for the timeframes required for the reports. If customers provide their PBM Name and EIN through the Client Portal, it will be included in the P2 report.

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

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

Q: If a customer was not using AmeriHealth Administrators services for both years 2020 and 2021, will AmeriHealth Administrators still submit data as above for the year in which it used your services? If not, please explain how AmeriHealth Administrators will support the customer.
A: AmeriHealth Administrators will include any customer that was active during any part of the reported reference year using information currently available in our systems. If customers do not use the AmeriHealth Administrators PBM, only medical cost reports (D1-D2) will be submitted. Customers with pharmacy coverage not managed by AmeriHealth Administrators will not be included in D3-D8 files.

Q: How will AmeriHealth Administrators handle data submissions if AmeriHealth Administrators 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 Administrators will only include customers that were active with it during the reporting timeframes within the reference year.

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

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

Q: Will employers have the ability to verify submissions when AmeriHealth Administrators 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 Administrators retain the RxDC submission?
A: AmeriHealth Administrators will follow its standard policy for data retention of CMS reporting.

Q: Will AmeriHealth Administrators 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 Administrators will address audit requests according to its policies and the applicable law, if/when these updates are published.

Q: [Updated as of 10/11/23] **For former customers/plan sponsors that are no longer contracted with AmeriHealth Administrators services, what program options does AmeriHealth Administrators support for CAA reporting requirements?**
A: AmeriHealth Administrators will include all available information for customers who were active during any part of the reported reference year based on the data AmeriHealth Administrators currently has within its systems for the timeframes required for the reports.

Q: Who should the customer contact to engage support for historical records support? (i.e., former account team, carrier/PBM mailbox, etc.)
A: AmeriHealth Administrators 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: For Customers who are supported by AmeriHealth Administrators preferred PBM, what program options does AmeriHealth Administrators preferred PBM support for CAA reporting requirements?
A: AmeriHealth Administrators will produce and submit data files, as a service to our self-funded customers, based on the data we currently have within its systems for the timeframes required for the reports. If the self-funded client has Optum Rx as their PBM, Optum Rx will provide the Rx Data to AmeriHealth Administrators. AmeriHealth Administrators will submit all files to CMS on one 'reporting' package. For self-funded customers with coverage through a different PBM, data for the D3 through D8 files will not be included in our reporting package.

Q: Does AmeriHealth Administrators have sample contract language to include in self-funded plan sponsor ASAs to document compliance with the RxDC reporting requirements?
A: No. the Administrative Service Agreement addresses new laws and regulations. AmeriHealth Administrators is providing a service to the Self-funded Customer and compliance with all associated regulatory requirements and attestations is the responsibility of the self-funded groups health plan.

Q: [Updated as of 10/11/23] **Does AmeriHealth Administrators need consultants to send AmeriHealth Administrators the premium equivalent rates that they may have developed on behalf of the customer?**
A: Based on CMS RxDC reporting requirements for "D1: Premium and Life-Years" AmeriHealth Administrators will generate aggregate level premium equivalent rates across the self-funded market segment based on internally available data for the first submission on December 27th. Due to the nature of aggregate reporting, the discrepancies between specific customer premium equivalent rates are not material enough to warrant data collection from consultants or customers.

For the June 1, 2024, and future yearly reports, Section 204 – RxDC submission to CMS, AmeriHealth Administrators 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] **For the June 1, 2024 filing deadline, is AmeriHealth Administrators reporting and filing at aggregate level or will AmeriHealth Administrators be using customer specific info?**
A: AmeriHealth Administrators 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 continue to have access to the portal unless they request access to be removed. 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 Administrators will need PPO and HMO/POS/DPOS total employee contribution reported separately.

Q: For insured groups, does AmeriHealth Administrators need to know the employer contributions and cost for the reference year?
A: Yes. The employee contribution is required from all customers (self-funded and insured). 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 AmeriHealth Administrators 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 Administrators submit the attestation for insured and self-funded customers, or are the customers responsible for submission?**

A: Yes, AmeriHealth Administrators will submit the attestation for insured and self-funded customers by the required date from CMS. Additional details will be published at the future date.

- **Insured groups:** AmeriHealth Administrators will submit the annual attestation covering the dates of December 27, 2020, through date of submission, on behalf of all groups. The attestation will be complete by the deadline of December 31,2023.
- **Self-funded groups:** An amendment to all current ASA will be distributed in October 2023 to state that AmeriHealth Administrators will submit the annual attestation covering the dates of December 27, 2020, through date of submission, on behalf of all groups. Self-funded groups will have the option to respond with an opt-out, meaning that the group will be responsible for submitting the Gag Clause Attestation to CMS by the due date of December 31,2023. Plan/Plan Sponsor must notify the Claims Administrator if the if Plan/Plan Sponsor intends to submit its own attestation confirming prohibition of use of gag clauses. By **November 15, 2023**, notify Claims Administrator at the following email address: contractsaha@ahatpa.com.

  If the Plan/Plan Sponsor does not notify Claims Administrator by **November 15, 2023**, of its intent to submit its own attestation, the Plan/Plan Sponsor acknowledges that Claims Administrator will be submitting an attestation for Services provided by Claims Administrator on behalf of the Plan/Plan Sponsor.

  If the Plan/Plan Sponsor does not opt-out, they will be asked to respond to a web-based form to collect details that are needed for AmeriHealth Administrators to submit the attestation. A link to this web-based form will be included in the amendment mailing.

  For self-funded customers who have AmeriHealth Administrators medical but carve out prescription drug or mental health services to other vendors, AmeriHealth Administrators can't file the attestation for Pharmacy Benefits and Behavioral Health Provider contracts.

Q: [New as of 10/11/23] **Will AmeriHealth Administrators be submitting the attestation for termed customers?**

A: AmeriHealth Administrators 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 Administrators 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: Is AmeriHealth Administrators compliant with the CAA's prohibition on gag clauses that restrict sharing of price and quality data by providers?

A: Yes.

Q: Will there be any additional fees?

A: There will not be any additional fees related to implementation of the prohibition on gag clauses.

Q: [Updated as of 10/11/23] **Will AmeriHealth Administrators submit the attestation for self-funded customers or are the customers responsible for submission?**
A: Yes, AmeriHealth Administrators will submit the attestation on behalf of the self-funded customers by the required date from CMS. The administrative services agreements with self-funded customers will be amended to include a provision in which the self-funded customer authorizes us to submit the attestation on behalf of the Plan Sponsor. Additional details will be published if additional information is required from the self-funded customer.

Q: Will AmeriHealth Administrators be assisting plan sponsors with the attestation pertaining to gag clauses due to the federal government by December 31, 2023?
A: AmeriHealth Administrators 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 Administrators to submit the attestation on behalf of the plan sponsor.

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

Provider Contracts

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

Q: What impact, if any, will these changes have on the administrative fees?
A: There will be no impact to administrative fees.

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 Administrators 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 Administrators 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 Administrators is coordinating the cross-functional, enterprise-wide implementation of the CAA and TCR requirements.

A: AmeriHealth Administrators established an enterprise-wide implementation program in accordance with the requirements applicable to them. The requirements for implementing the CAA and TCR are evolving.

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

A. AmeriHealth Administrators public sites and EOBs will contain the balance billing disclosure, outlined in the CAA.

Q: How and when will updates on AmeriHealth Administrators compliance with the various requirements of the CAA and TCR be disseminated to customers?

A: AmeriHealth Administrators will comply with the laws by the compliance dates. As is AmeriHealth Administrators standard practice, AmeriHealth Administrators will share information about its compliance and outreach via *Market Edge* communications. AmeriHealth Administrators will be communicating with members directly for AmeriHealth Administrators customers unless directed otherwise by self-funded customers.

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

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

Q: Will AmeriHealth Administrators support group customers' communication to their employees on these changes and new resources?

A: AmeriHealth Administrators will communicate changes and new resources to our customers. Self-funded customers will still be responsible for communicating to their employees and sharing materials and information as it becomes available.

Q: If a group health plan uses a third-party vendor to generate price comparison and/or cost-sharing estimates, would AmeriHealth Administrators share member-level accumulator information and other necessary data elements at no additional charge with the EOB vendor once appropriate data-sharing agreements are in place? If no, explain.

A: No. AmeriHealth Administrators responses to requests for member-level accumulator information and other data elements will need to be evaluated and if accepted will be provided at an additional charge to cover AmeriHealth Administrators costs associated with providing the response.

AmeriHealth Administrators standard transparency tools as required by the TCR and CAA will be available at no additional cost.

Q: List any third-party vendors or subcontractors AmeriHealth Administrators 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
- HealthSparq (now owned by Kyruus)

- FirstHealth
- MultiPlan/PHCS

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

A: AmeriHealth Administrators 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. The plan sponsor is responsible for implementing the requirements for self-funded group health plans. Self-funded groups may contact a third-party administrator to implement any of the requirements of the rule.

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.

While this data may pose challenges, 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 Administrators, 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: The Federal Government issued additional guidance about the Transparency Rule's requirement that MRF be posted on a health plan's website. Will AmeriHealth Administrators be handling the MRF posting on behalf of self-funded customers?

A: The guidance establishes an option for third party administrators to post MRF links on behalf of a self-funded customer. After review of the guidance, AmeriHealth Administrators has decided it will not create websites to post the MRF links for self-funded customers. AmeriHealth Administrators recommends that self-funded customers discuss the guidance with their legal counsel so that the self-funded customer can determine how it can comply with the guidance.

Q: Are the files sent to CMS?

A: No.

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

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

Q: Please describe the process for delivering links to required MRFs to self-funded plan sponsors.

A: AmeriHealth Administrators will produce in-network and out-of-network machine readable files (MRFs) for each customer. Self-funded customers will be provided links to the appropriate file for each of their plans. AmeriHealth Administrators will send a monthly email to the self-funded customer's

mandate email address with the link or links the customer can post to their public website. AmeriHealth Administrators will utilize the CMS GitHub Table of Content (ToC) option which will reduce the number of links required.

Q: Will AmeriHealth Administrators be posting all the MRFs to a single page or will there be customer-specific pages?

A: AmeriHealth Administrators will provide self-funded customers with a URL to the required MRF which a customer can post to their public website. To do that, AmeriHealth Administrators requires the name and email address of the person the customer wants to receive the unique URL for the MRFs. This person will serve as the customer's MRF contact. This contact will receive the URL link(s) via email.

Q: What should a self-funded customer do once they receive their URL link(s)?

A: Self-funded customers will need to post the URL links(s) on the customer's public website immediately. The URL link is not expected to change. The data files will be automatically refreshed each month. If you are working with a third-party vendor for the MRFs, please check with the vendor regarding a name and email address.

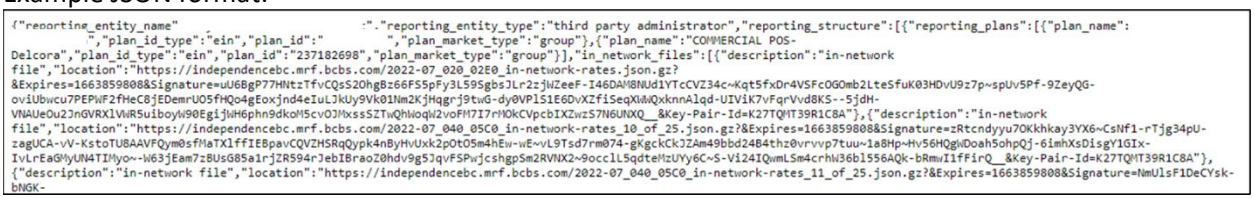
Q: What format should the data be displayed according to the requirements? Indicate which file format AmeriHealth Administrators will utilize.

A: For self-funded customers, the name of the MRF Index will follow this format: **https://storage.googleapis.com/ihg-dart-edw-mrf-prod-public/aha/YYYY-MM-DD_67890_index.json**.

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: If a plan sponsor does not want to post the links on their own public website, will AmeriHealth Administrators create an employer-specific website for them?

A: No.

Q: If a plan sponsor requests it, will AmeriHealth Administrators send updated links to third-parties who create employer-specific websites to post links to the MRFs?
A: No.

Q: When will the files be updated each month? (e.g. by the 15th of every month, 2nd Tuesday of the month). Will AmeriHealth Administrators push notification to the customer when the files update?
A: The files will be updated by the 10th of every month. Self-funded customers will receive an email once the files are ready.

Q: Will the files include plan-specific information (e.g., plan name, number, sponsor EIN) as required by the regulations?
A: The in-network file will not include plan-specific information. The OON allowed amount file will contain customer specific reporting information.

Q: Will AmeriHealth Administrators be providing a Table of Contents file to post multiple networks/plans? If yes, will there be plan-specific information included?
A: Yes, each customer will have a Table of Contents.

Q: Will files differ by customers if both customers have the same network arrangement, and how will they differ?
A: Yes, the files will differ depending on the Customers networks.

Q: How will special cost arrangements (such as domestic networks for hospital employers) be handled in an employer's machine-readable file?
A: AmeriHealth Administrators will not be incorporating external data for non-preferred, customer specific vendors. Customers should work directly with those vendors to receive the necessary data.

Q: How will AmeriHealth Administrators treat carve-out arrangements (e.g., on-site clinics, carve-out surgical networks, virtual care)? Will these be included in the Machine-Readable Files?
A: TCR requires AmeriHealth Administrators to make rates available from AmeriHealth Administrators contracting providers. Since vendors are not contracting providers, they are not included.

Q: Will AmeriHealth Administrators maintain the monthly MRFs on behalf of each employer?
A: Yes.

Q: For very large files, will a checksum or hash value be posted to help confirm that files have not been corrupted in posting/transfer?
A: No.

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 the information provided in the MRFs.
A: AmeriHealth Administrators 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. Any special requests will need to be discussed with your Account Management team and any fees evaluated.

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 AmeriHealth Administrators website. If not yet available, please confirm where and when it will be posted.
A: The files will not be posted to AmeriHealth Administrators website. We will provide self-funded customers with a URL to the required MRF which a customer can post to their public website

Each self-funded customers will be directed to a customer specific link that follows this pattern: **https://www.ahatpa.com/transparency-in-coverage/67890?key=xxxxxxx.** By clicking the customer specific link, the customer will obtain their specific MRF Table of Contents file link. The name of the customer specific MRF Table of Contents will follow this format: **https://storage.googleapis.com/ihg-dart-edw-mrf-prod-public/aha/YYYY-MM-DD_67890_index.json** and contain a series of links to in-network MRF json files specific to their plans and out-of-network MRFs specific to their business**.**

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: For plan sponsors working with third party vendors to aggregate, post, or otherwise satisfy the machine-readable file requirements of the TCR, will AmeriHealth Administrators share the necessary data and information with these third parties at no additional charge, subject to appropriate data agreements being in place?
A: No. Additional requests for data and other information will be evaluated and if accepted will be provided at an additional charge to cover our costs associated with providing the response.

Q: In addition to creating the Machine-Readable files, will AmeriHealth Administrators retain historical copies of the Machine-Readable Files to help customers satisfy ERISA's record retention requirements?
A: AmeriHealth Administrators will retain MRF data for 10 years. Each self-funded ERISA plan sponsor will need to maintain information in its possession according to the appropriate timeframe.

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: Can AmeriHealth Administrators confirm whether AmeriHealth Administrators will produce and host the files for self-funded customers, and whether there is a cost? If there is a cost to host the files, can wellness credits or other similar funds be used toward the cost?
A: AmeriHealth Administrators will produce and support MRFs based on requirements for customers. Data will be updated monthly, as required. AmeriHealth Administrators will provide a direct URL that can also be added to an employer's internet site. AmeriHealth Administrators has decided it will not create websites to post the MRF links for self-funded customers. AmeriHealth Administrators recommends that self-funded customers discuss the guidance with their legal counsel so that the self-funded customer can determine how it can comply with the guidance.

Q: Will AmeriHealth Administrators incorporate external data (e.g., PBM, specialty network, etc.)?
A: No. AmeriHealth Administrators will only incorporate data from AmeriHealth Administrators preferred vendor partners (i.e., Optum Rx). Customers should work directly with their vendors to receive necessary data.

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: AmeriHealth Administrators agreements already state that AmeriHealth Administrators 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 Administrators does not anticipate any issues with including prescription drugs administered through the medical plan.

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 Administrators respond to questions regarding any missing values such as NPI, procedure codes, etc.?
A: AmeriHealth Administrators will update data as needed and will develop a process to respond to inquiries regarding the files.

Miscellaneous Questions

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

Q: Who has primary accountability at AmeriHealth Administrators 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 Administrators (e.g., quarterly report outs to CEO, Board of Directors, etc.)?
A: AmeriHealth Administrators distributes weekly project status reports and has monthly meetings with Senior Leadership.

Q: Does AmeriHealth Administrators 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 Administrators is actively identifying, evaluating, and managing risks with these initiatives.

Q: What is AmeriHealth Administrators communication plan for those not digitally engaged when trying to send updates about the new regulations?
A: AmeriHealth Administrators is actively developing a communication strategy for all customers. Additionally, AmeriHealth Administrators posts detailed information on AmeriHealth Administrators corporate website.

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