Transparency Requirements

At Highmark, we strongly support greater transparency and are committed to providing members with the health care quality and price information they want and need to make the best decisions for themselves and their families.

Our 20 years of experience with consumer tools tell us that most people want clear information about their own out-of-pocket costs, the quality of care provided by their doctors and whether their doctors, hospitals, and other clinicians are in their network.

We want shopping for elective medical services to become part of the click-and-compare world. Today, the independent licensees of the Blue Cross Blue Shield Association (BCBSA) provide cost transparency tools to consumers in every state, many of which allow consumers to obtain information on the cost and quality of certain procedures, while safeguarding consumer information. These tools are tailored to the consumers' own coverage and benefits, including information on co-pays and progress towards meeting deductibles.

To address the Consolidated Appropriations Act (CAA)/No Surprises Act (NSA) and the Transparency in Coverage Rule (TCR), Highmark established procedures for implementation of regulatory guidance, in which we have dedicated workstreams to execute internal procedures (including required technology) for each requirement within these requirements. Our organization is on track to be compliant by the applicable effective dates of January 1, 2022, January 1, 2023, and January 1, 2024, and continues to keep a pulse on additional anticipated rulemaking.

Here are some answers to common questions:

Q What data will be provided and when?

A The TCR requires non-grandfathered group health plans to disclose on public websites information regarding in-network provider rates for covered items and services, out-of-network allowed amounts, and billed charges for covered items and services and negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. The machine-readable file requirements of the TCR are applicable for plan years beginning on or after January 1, 2022.

Highmark will provide all three files (in-network rates, out-of-network allowed amounts, and prescription drugs) monthly. Clients will need to work with their Pharmacy Benefits Manager directly if their pharmacy benefit is carved out. The machine-readable files will be available on a Highmark public website. Training will be provided to clients on how they can locate their information and how to interpret the files.

Highmark has been reviewing agency guidance and FAQs published by the U.S. Departments of Health and Human Services, Labor and the Treasury on August 20, 2021. At this time, we are continuing our efforts to support the implementation of provisions outlined in CAA and TCR.

What role has BCBSA played in ensuring readiness?

BCBSA developed multiple resources to ensure readiness amongst its licensees. These resources include a procedural manual and file transfer access instructions. BCBSA has provided a data file layout for the in-network file exchange through their Data Hub for inter-plan products and coverages. Additionally, BCBSA has held subject matter expert meetings for machine readable files to assist with the development of the in-network file solution. Lastly, BCBSA is requiring all licensees to complete milestone surveys so they can keep a pulse on the progress of their implementation.

What gaps still exist, if any?

At this time, the file size of the in-network file continues to be a concern, however, there are no major gaps in the process.

What is the Price Comparison Tool?

TCR rules require plans to make price comparison information available to members through an internet-based self-service tool and in paper form, upon request. This information must be available for plan years beginning on or after January 1, 2023, with respect to the 500 items and services and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.

The CAA requires plans to offer price comparison guidance by telephone and make available on the plan's or issuer's website a "price comparison tool" that (to the extent practicable) allows an individual enrolled under such plan or coverage, with respect to such plan year, such geographic region, and participating providers with respect to such plan or coverage, to compare the amount of cost-sharing that the individual would be responsible for paying under such plan or coverage with respect to the furnishing of a specific item or service by any such provider. This requirement is applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Today our cost estimation tools are powered by BCBSA data and developed in accordance with BCBSA rules. There is a team of cross-disciplinary representatives at Highmark and the BCBSA that are determining how changes in the regulatory environment may affect how we display cost.

Highmark currently provides an internet-based self-service price comparison/cost estimation tool that allows members and providers to obtain information on the cost of certain procedures, which meets the requirements set forth within the CAA, as the law is currently written. For the TCR, Highmark is enhancing our internet-based self-service tool to include the identified 500 shoppable services and the required data elements. Additionally, effective January 1, 2024, Highmark will enhance our internet-based self-service tool to include all covered items and services, including prescription drugs and durable medical equipment.

NOTE: Additionally, because plans and issuers have already been expecting to implement the first phase (500 items and services) of the internet-based self-service tool of the TCR rules for plan years beginning on or after January 1, 2023, and have been working towards that applicability date, as an exercise of enforcement discretion, the agencies have elected to defer enforcement of the requirement that a plan or issuer makes available a price comparison tool (by internet website, in paper form, or telephone) before plan years beginning on or after January 1, 2023, aligning the enforcement date of the CAA with the TCR requirements.

ID Card (cost share transparency)

All Highmark members will receive new Member ID Cards in 2022. The new ID Cards will be issued upon client renewal, or upon the anniversary of the client's Plan Year, whichever comes first. New card formats that display the individual and family program deductible and out-of-pocket Maximum/Limit are being developed for all Highmark products.

Advanced EOBs

Health plans are required to provide an advanced explanation of benefits ("EOB") for scheduled services. We anticipate the Tri-Agencies to release data transfer standards, and will finalize our solution once additional notice-and-comment rulemaking is published. The Advanced EOB requirement effective date has been delayed by the regulatory agencies and will be implemented at a future date still to be determined.

Contractual Gag Clauses

The CAA prohibits plans and issuers from entering into an agreement with a provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from (1) providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (2) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; and (3) sharing such information, consistent with applicable privacy regulations. In addition, plans must annually submit to the agencies an attestation of compliance with these requirements. These provisions are effective December 27, 2020 (the date of enactment of the CAA).

Highmark provider contracts do not include gag clauses. Furthermore, Highmark will comply with applicable disclosure provisions of the CAA subject to the execution of an appropriate confidentiality agreement.

Accurate Network Directories

The CAA requires plans to establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a provider's network participation status. If a participant, beneficiary, or enrollee is furnished an item or service by a nonparticipating provider or nonparticipating facility, and the individual was provided inaccurate information by the plan or issuer under the required provider directory or response protocol that stated that the provider or facility was a participating provider or participating facility, the plan or issuer cannot impose a cost-sharing amount that is greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider or participating facility and must count cost-sharing amounts toward any in-network deductible or in-network out-of-pocket maximum. These provisions are applicable with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2022.

Highmark is implementing new software and procedures that require contracted providers to verify their critical demographic information in the Highmark provider directory every 90 days. In addition, internal processes are being updated to ensure all provider information

updates received by Highmark are reflected in the Highmark provider directory within 48 hours of receipt.

What is No Surprise Billing disclosure?

No Surprise Billing disclosure language that complies with the NSA will be posted on the Highmark member portal. Similar disclosures will appear on EOB's for services rendered by out-of-network providers. In addition, new claim line-specific messages will appear on EOB's for claim lines that are identified as subject to No Surprise Bill regulations.

We will provide information (including updated member benefit booklets) to help clients update their SPDs to reflect the requirements of the NSA.

What benefit changes are required due to the No Surprises Act?

For plans subject to the NSA, they must provide benefits at the network level of cost sharing whenever certain covered services are rendered by out-of-network providers.

As a result, many groups will need to make benefit changes when they renew in 2022 to comply with the NSA.

1. Cover emergency claims at the network level of benefits (subject to network deductible, OOP, TMOOP and copay/coinsurance) when provided by an OON provider. Services must be covered at the highest tier for tiered products. This includes both Facility and Professional claims but does not include Ambulance claims.

2. Cover (emergency and non-emergency) Air Ambulance claims (if Air Ambulance services are a covered benefit) at the network level of benefits (subject to network deductible, OOP, TMOOP and copay/coinsurance) when provided by an OON provider. Services must be covered at the highest tier for tiered products. Air Ambulance services are standardly covered by Highmark benefit plans, but the Act does not require groups to cover Air Ambulance services. Highmark will continue to review certain Air Ambulance claims for medical necessity and will deny claims that do not meet medical necessity criteria as outlined in the Highmark Medical Policy.

Continuity of Care

The CAA established continuity of care protections that apply in the case of an individual with benefits under a group health plan. These protections ensure continuity of care in instances when terminations of certain contractual relationships result in changes in provider or facility network status. These provisions are applicable with respect to plan years beginning on or after January 1, 2022. Until rulemaking to fully implement these provisions is adopted and applicable, plans are expected to implement the requirements using a good faith, reasonable interpretation of the statute.

Continuity of Care (COC) is an existing process that allows members to receive treatment from OON providers at the network level benefits under specific circumstances. The process

itself is not changing substantially as a result of the NSA. What is changing is that the population of members eligible for COC has been expanded by the NSA.

When there is a change in Highmark's provider network (i.e., the provider/facility is no longer contracted with Highmark, the provider/facility leaves Highmark's network, or if the provider/facility is moved from a broad to narrow network), members undergoing continuous care may continue to receive services from the now out-of-network provider for up to 90 days under the terms and conditions that were applicable prior to the change to allow for a transition of care to an in-network provider.

If the patient chooses to continue with their current provider, the provider must accept the previous in-network payment and cost-sharing rates for those 90 days/or until the treatment is concluded, whichever is sooner.

The legislation defines continuing care patients as those who:

- Are undergoing a course of treatment for a serious and complex condition
- Have an acute illness serious enough to require specialized medical treatment to avoid death or permanent harm
- Have a chronic illness that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized care
- Are receiving institutional or inpatient care
- Are scheduled to undergo nonelective surgery, including postoperative care
- Are pregnant and undergoing treatment for pregnancy
- Are/were determined to be terminally ill and are receiving treatment for such illness

Health Care Cost Reporting

Highmark is working with our Pharmacy Benefit Manager (PBM) to provide the pharmacy rates and files required by Section 204 of the Consolidated Appropriations Act. Our solution is currently in development since additional rulemaking is expected from the U.S. Departments of Health and Human Services, Labor and the Treasury to address the pharmacy benefit and drug reporting requirements.

Self-insured clients with carve-out Pharmacy should work directly with their PBM.

Mental Health Parity: Non-Quantitative Treatment Limitations

Overview

On December 27, 2020, H.R. 133 Consolidated Appropriations Act (CAA) became law. The Consolidated Appropriations Act, 2021 (CAA), Section 203, requires group health plans and issuers that cover mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits to prepare a comparative analysis of any nonquantitative treatment limits (NQTLs) that apply when explicitly requested by a state authority or federal Secretaries, as applicable.

What do employers need to know about the Consolidated Appropriations Act of 2021 (CAA)?

A

Many of the COVID-19 financial aid packages were set to expire at the end of the year. The Act aims to provide additional economic relief to industries, organizations, and individuals affected by the COVID-19 pandemic. Key provisions for employers include modifications to PPP loan forgiveness, a second round of PPP loans for the most impacted small businesses, extended and enhanced tax credits, and a final determination on the deductibility of expenses paid using PPP loan proceeds. The Consolidated Appropriations Act of 2021 (CAA) provides $900 billion in aid and extends many of the provisions introduced under the CARES Act. Among provisions for individuals, such as direct cash to workers, rental assistance, and a ban on surprise medical bills, the CAA also enhances aid for small businesses and renews the Paycheck Protection Program. One of the requirements to this bill includes **group health plans and issuers that cover mental health/substance use disorder (MH/SUD) and medical/surgical (M/S) benefits to prepare a comparative analysis of any nonquantitative treatment limits (NQTLs) that apply when explicitly requested by a state authority or federal Secretaries, as applicable.** NQTLs are non-numerical requirements that could limit the scope or duration of services for the treatment of a mental health or substance use disorder benefit, such as medical management, provider reimbursement, geographic and facility type limitations, etc.

When is this effective?

A

Beginning February 10, plans must supply this analysis and other information if requested by state authority or federal Secretaries, as applicable (the Department of Labor [DOL] for ERISA plans).

What is the Intent?

A

In the face of a pandemic, access to mental health care and substance use disorder support is more critical than ever. Unlike many of the other provisions of the CAA that affect group health plans, the MHPAEA requirement went into effect on February 10, 2021. This is clearly a priority- guarding access and removing barriers to mental health care.

What's the objective?

To secure and bolster the MHPAEA and ensure that group health plans that provide mental health and substance use disorder benefits don't impose less favorable terms and conditions on MH/SUD benefits than on medical and surgical benefits.

Is Highmark aware of the NQTL compliance disclosure set forth by the CAA?

Yes, Highmark is aware of and continuously monitors for Federal and State guidelines regarding compliance metrics related to NQTL.

Is Highmark compliant with the NQTL section of the CAA?

Yes, Highmark will be able to provide the comparative analysis to the requesting regulator within the time parameters provided.

Will Highmark assist self-insured clients with specific requests from regulators regarding the NQTL comparative analysis?

Yes, Highmark will support each client when the official request from a regulator is received to ensure the requested information is provided in a timely fashion and will be available to assist the client/regulator with any subsequent follow-up questions.

What happens if the regulator requests additional information regarding the NQTL analysis?

Per the law, if the regulator requests additional quantitative analysis information after the initial submission, plans have an additional 45 days to provide said documentation. During that timeframe, Highmark will assemble and provide the additional information requested and provide it back to the client prior to the submission deadline.

Highmark will continue to issue updates as we work through all aspects of implementation.

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Highmark Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.