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

For use with customers, brokers, and consultants

Updated August 24, 2022

AmeriHealth New Jersey further sharpens efforts on transparency

AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) 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 New Jersey understands that the federal government will be issuing additional guidance. The guidance issued by the federal government will impact AmeriHealth New Jersey's implementation of the CAA and TCR.

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

AmeriHealth New Jersey will continue to update these FAQs as AmeriHealth New Jersey receive additional guidance and updated FAQs will be communicated via the *Market Edge* newsletter. AmeriHealth New Jersey will be in compliance with the CAA and TCR by the required compliance dates. This FAQ can always be accessed on the AmeriHealth New Jersey Business Hub, https://www.amerihealthnj.com/html/custom/covid-19-employers/index.html.

To easily access a provision section in this FAQ, click on the line item on the Table of Contents on the next page.

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Table of Contents

Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 (CAA) was signed into law in December 2020. Among other provisions, the CAA includes many provisions that affect how AmeriHealth HMO, Inc. and AmeriHealth Insurance Company of New Jersey (collectively, AmeriHealth New Jersey) provides health care coverage. Since the CAA was enacted, the federal government issued guidance about the CAA. Recently, 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.

Surprise Medical Billing Patient Protections.

For plan years beginning 1/1/2022 forward, members will be 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. The federal government will be issuing further guidance about the IDR process.
- **Application of Protections to Ambulance Services.** Members using air (but not ground) 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.

AmeriHealth New Jersey is currently analyzing how these Federal requirements interplay with the existing New Jersey surprise billing patient protection law.

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 recently 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. Further guidance is expected in 2022, however 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. Further guidance is expected in 2022, however health plans are expected to implement using a good faith, reasonable interpretation until further guidance is issued.

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 will not issue guidance addressing ID cards prior to the 1/1/2022 compliance date; however, the federal government does intend to issue guidance. In the interim, 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. This requirement will not be enforced pending further guidance by the federal government; however, health plans are encouraged to start working to begin reporting by 12/27/2022 for 2020 and 2021 plan years.

Air Ambulance Reporting. Requires health plans to submit two years of claims data to be compiled by the Department of Health and Human Services 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 2022 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 New Jersey be in compliance with the CAA by 1/1/2022?
A: AmeriHealth New Jersey is committed to meeting the requirements of the CAA applicable to it by the compliance dates.

Advanced EOB (AEOB)

Q: What are AmeriHealth New Jersey's plans for accommodating the CAA requirement to provide AEOBs to members in 2022?
A: For participating providers, AmeriHealth New Jersey is using the PEAR Portal; for non-participating providers, the request for AEOBs can be made via a customer service request.

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

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

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

Cost Comparison Tool

This has been delayed until 2023 with the intent to align with the TCR price transparency tool requirements.

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

Q: Do you intend to build and manage a price transparency tool on behalf of AmeriHealth New Jersey groups?
A: Yes. Further details will be provided by the mandatory compliance date.

Q: Will AmeriHealth New Jersey 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 New Jersey will comply with the law as required by the compliance date and provide a standard compliance implementation. Anything custom would need to be requested by the groups. AmeriHealth New Jersey's current tool is already compliant for the majority of AmeriHealth New Jersey's business.

Q: When will AmeriHealth New Jersey's platform be ready to launch?
A: AmeriHealth New Jersey will comply with the law by the compliance date.

Q: How will the cost comparison tool be made available to consumers (e.g., online self-service and/or by phone)?
A: The cost comparison tool will be made available in the same manner it is today through amerihealthnj.com and the AmeriHealth New Jersey mobile app. AmeriHealth New Jersey can also produce cost estimates on behalf of members by calling customer service (i.e., by phone).

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.

ID Cards

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

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

Q: Will virtual ID cards that meet requirements be available starting 1/1/2022?
A: They will be available on or before the group's renewal date on the member portal and mobile app.

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: What date does AmeriHealth New Jersey need renewal decisions to produce ID cards in a timely fashion?
A: ID card generation is dependent upon receipt of benefit changes from a group and a clean enrollment file. The typical SLA to guarantee cards in hand prior to the effective date is 30 days in advance of renewal and 10 days upon receipt of a clean enrollment file. It could be longer than 10 days due to projected mail delays at the post office. The sooner AmeriHealth New Jersey has a decision, the quicker the card will come.

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: [Updated as of 8.24.22] **Will AmeriHealth New Jersey be in compliance by the effective date?**
A: AmeriHealth New Jersey's current "Continuity of Care Coverage" process, for its contracted providers is compliant with the requirements of the CAA

Q: [Updated as of 8.24.22] **What is the process to ensure continuity of care?**
A: AmeriHealth New Jersey's current "Continuity of Care Coverage" process is compliant with the requirements of the CAA. AmeriHealth New Jersey notifies the members when contracted provider leaves the network. Member can outreach and request Continuity of Care, which is subject to Medical Director review.

Q: [Updated as of 8.24.22] **Do members receive a network disruption letter that indicates options for continuity of care in certain instances and action they need to take?**
A: AmeriHealth New Jersey's current "Continuity of Care Coverage" process is compliant with the requirements of the CAA. AmeriHealth New Jersey notifies the members when contracted provider leaves the network. The notice includes directions for member to follow.

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

Q: Will AmeriHealth New Jersey 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 New Jersey's current "Continuity of Care Coverage" process is compliant with the CAA. Up to 90 calendar days of continuity of care is offered to the member through the current period of active treatment for an acute condition or through the acute phase of a chronic condition, after which they must seek care from a provider within the network specified by their product. Continuity of care determinations are made based on medical necessity.

Provider Directories

Q: [Updated as of 8.24.22] **Will AmeriHealth New Jersey be in compliance by the effective date?**
A: AmeriHealth New Jersey is committed to meeting the requirements by the required compliance dates. AmeriHealth New Jersey Provider Directory updates meet the requirements of the CAA.

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

Q: [Updated as of 8.24.22] **What is being done to ensure frequent data updates?**
A: Internal processes are being modified to update the required fields in the provider directory based on requirements of the CAA. Updates to data elements, received from providers and required by mandate are prioritized for 2 days turnaround. Online Provider Directory is updated daily.

Q: What is the process to confirm a member relied on inaccurate provider directory information from the carrier website, and what steps will AmeriHealth New Jersey 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 New Jersey has an existing process, performed by Customer Service to ensure cost-sharing reflects the participating status of the provider, based on member request. The Member must provide proof he/she received incorrect information on the provider's participation status. Proof of an incorrect provider directory entry should be either that the online provider directory is still displaying an out-of-network provider as in-network, or the member has print screen/printout of the directory listing the out-of-network provider as in-network.

Q: Will the required balance billing disclosure be present on the site and EOBs by the effective date?
A: Public sites and EOBs contain disclosures, outlined in the CAA.

Q: [Updated as of 8.24.22] **Will you notify employers of directory updates?**
A: AmeriHealth New Jersey will ensure compliance with the federal and state requirements for managing and presentment of provider directory information, but due to the frequency and volume of provider data changes, Independence will not be able to support account notification when updates have been made.

The updated date of the directory is listed on the directory site.

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

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

Q: [Updated as of 8.24.22] **If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how AmeriHealth New Jersey will administer the claim at the in-network level?**
A: AmeriHealth New Jersey will update the online provider directory as required by the CAA; AmeriHealth New Jersey updates the online provider directory daily. Members who rely on information which is incorrect will not be liable beyond the in-network level of benefits and applicable cost-share. Such circumstances likely do not become known unless the member inquires and/or appeals a benefit determination in accordance with the health plan rules and procedures.

Broker and Consultant Compensation Disclosure

Q: [Updated as of 8.24.22] **Will AmeriHealth New Jersey be in compliance with the new disclosure requirements related to broker and consultant compensation by the effective date?**

A: Yes. If you use a broker to help facilitate your consumer enrollment, their compensation is a flat fee per member, per month. This is paid by AmeriHealth New Jersey. Your monthly premium will be the same whether you choose to use a broker or not. In addition, your broker may receive a bonus if certain sales thresholds are met.

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

Surprise Billing

Q: How is AmeriHealth New Jersey working to comply with CAA's No Surprises Act provisions?

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

Q: What should a member do if they receive a surprise medical bill that is otherwise prohibited under the new regulations?

A: Cost Information for Out-of-Network Treatment is available on https://www.amerihealthnj.com/html/members/out-of-network.html. Members can also call customer service number on the back of their ID card.

Q: [Updated as of 8.24.22] **Describe any services in support of compliance with CAA surprise billing protections that will be subcontracted or outsourced to enGen. List the name of each party and services provided by each.**

A: AmeriHealth New Jersey is using enGen as a platform vendor.

Q: Will you timely provide the air ambulance reporting on behalf of the plan to HHS?

A: AmeriHealth New Jersey will comply with the air ambulance reporting provision of the CAA by the compliance date.

Q: Describe the steps AmeriHealth New Jersey has taken to ensure compliance with the CAA's requirements regarding balance billing for OON emergency claims.

A: Consistent with the requirements of the CAA, AmeriHealth New Jersey made certain revisions to its claims processing system so that the specific out-of-network claims described in the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition, AmeriHealth New Jersey has developed a communication plan to inform members and providers about the CAA.

Q: Describe the steps AmeriHealth New Jersey has taken to ensure compliance with the CAA's requirements regarding balance billing for out-of-network services provided at in-network facilities.

A: Consistent with the requirements of the CAA, AmeriHealth New Jersey made certain revisions to its claims processing system so that the specific out-of-network claims described in the CAA will process as required by the CAA and subsequent regulatory guidance issued by the federal government. In addition,

AmeriHealth New Jersey has developed a communication plan to inform members and providers about the CAA.

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

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

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

Mental Health Parity and Addiction Equity Act - CAA

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

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

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

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

templated health plan designs. Turnaround time to receive the analysis of AmeriHealth New Jersey's templated health plan designs is approximately five business days.

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

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

General Questions

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

Q: [Updated as of 8.24.22] **Will AmeriHealth New Jersey post notice of the NSA requirements and include such notice in all EOBs for affected items and services?**

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

Q: How and when will updates on AmeriHealth New Jersey's compliance with the various requirements of the CAA and TCR be disseminated to customers?
A: AmeriHealth New Jersey will comply with the laws by the mandated compliance dates. As is our standard practice, we will share information about our compliance and outreach via our *Market Edge* communications. AmeriHealth New Jersey will be communicating with members directly for our AmeriHealth New Jersey customers unless directed otherwise by our self-funded customers.

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

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

Q: [Updated as of 8.24.22] **List any third-party vendors or subcontractors AmeriHealth New Jersey 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: AmeriHealth New Jersey's platform vendor

- HealthSparq (recently purchased by Kyruus): AmeriHealth New Jersey's transparency tool vendor

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

A: AmeriHealth New Jersey 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 (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.

The Final Rule 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.

The Rule'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
- 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; and

The Rule adopts a three-year, phased-in approach for compliance with the Rule, 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.

The Rule 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, the rule applies to health insurers and group health plans. AmeriHealth New Jersey is responsible for implementing the requirements for fully insured group health plans.

Machine-Readable Files

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

A: Enforcement for Machine Readable Files (MRFs) was delayed from January 1, 2022, to July 1, 2022, for negotiated in-network rates as well as out-of-network allowed amounts and billed charges. Enforcement for prescription drug costs (negotiated rates and historical net pricing) was deferred pending additional rulemaking. Once further rulemaking is issued, AmeriHealth New Jersey will work with AmeriHealth New Jersey's preferred vendor, Optum RX, to meet all necessary requirements.

Q: [New as of 8.24.22] **What does it mean for you as the employer?**

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

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

While this data may pose challenges in carrier cost comparisons, there is ample opportunity for employers to leverage this data to support consumerism within their populations. When used in conjunction with the transparency tools offered by Independence, 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: [New as of 8.24.22] **What are some complexities that require an element of interpretation with these MRFs?**

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

Q: [Updated as of 8.24.22] **What format should the data be displayed according to the requirements? Indicate which file format AmeriHealth New Jersey will utilize.**

A: Data files must be displayed in a standardized format and must be updated monthly. AmeriHealth New Jersey will be posting the data as a .JSON file. For fully insured customers, the name of the MRF

Index will follow this format: **yyyy-mm-dd_ahnj_index.json** (for AmeriHealth NJ Insurance Co, Inc.) or **yyyy-mm-dd_ahnjhmo_index.json** (for AmeriHealth HMO, Inc.).

Q: [New as of 7.6.22] **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: [New as of 7.6.22] **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: [New as of 7.6.22] **When will the files be updated each month? (e.g. by the 15th of every month, 2nd Tuesday of the month).**

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

Q: [New as of 7.6.22] **Will the files include plan-specific information (e.g., ERISA plan name, number, sponsor EIN) as required by the regulations?**

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

Q: [New as of 7.6.22] **Will AmeriHealth New Jersey combine multiple applicable networks for in-network files if the plan uses different networks in different locations? Will AmeriHealth New Jersey combine multiple applicable networks for in-network files if the plan offers multiple networks for different plan options?**

A: No, the MRFs are based on issuing company and will be posted on a table of contents.

Q: [New as of 7.6.22] **Do you have any sample files available, and if so, could you provide?**

A: No, sample files are not available.

Q: [New as of 7.6.22] **Will files be validated using the CMS schema validator prior to posting? (https://github.com/CMSgov/price-transparency-guide-validator)**

A: Yes.

Q: [New as of 7.6.22] **Describe the quality assurance process that will be in place to ensure accuracy of rates provided in the MRFs.**

A: AmeriHealth New Jersey 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: [New as of 7.6.22] **Will there be any additional fees associated with the Machine-Readable Files?**
A: There will be no additional fees for the standard files.

Q: [New as of 7.6.22] **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: [Updated as of 8.24.22] **Please confirm if the files will be posted to AmeriHealth New Jersey's website. If not yet available, please confirm where and when it will be posted.**
A: Fully insured customers will be directed to **https://www.amerihealthnj.com/html/developer-resources/index.html** where they can find the MRFs for AmeriHealth NJ Insurance Co, Inc. and AmeriHealth HMO, Inc. The name of the MRF Table of Contents will follow this format: **yyyy-mm-dd_ahnj_index.json** (for AmeriHealth NJ Insurance Co, Inc.) or **yyyy-mm-dd_ahnjhmo_index.json** (for AmeriHealth HMO, Inc.) per CMS requirements and provide an index of MRF links for AmeriHealth NJ Insurance Co, Inc. and AmeriHealth HMO, Inc.

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

Q: [New as of 8.24.22] **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: [Updated as of 8.24.22] **In addition to creating and hosting the Machine-Readable files, will AmeriHealth New Jersey retain historical copies of the Machine-Readable Files to help customers satisfy ERISA's record retention requirements?**
A: AmeriHealth New Jersey will provide self-funded customers with a link to the MRFs. This link should be posted on the customer's public website to comply with the requirements of the mandate. AmeriHealth New Jersey will store and retain the MRFs data for 10 years at no cost to our customers.

Q: What is AmeriHealth New Jersey's approach to supporting plan sponsors in satisfying their internal data retention policy, in the event of audit or contract termination.
A: All machine-readable files will be retained for 10 years.

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

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

Q: How will the requirements outlined in the TCR impact contracts with groups? Which provisions from the TCR will be addressed in plan-sponsor contracts?
A: AmeriHealth New Jersey's agreements already state that AmeriHealth New Jersey 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 New Jersey does not anticipate any issues with including prescription drugs administered through the medical plan. Medical drug rates will be included in the in-network rate file. Out-of-network medical drug allowed amounts will be included in the allowed amount file. Prescription drug rates would be included in the third machine readable file once additional guidance is received from the federal government.

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

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

Gag Clause

Q: Does the current AmeriHealth New Jersey 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: AmeriHealth New Jersey's agreements with groups require that AmeriHealth New Jersey must comply with all applicable laws.

Provider Contracts

Q: Is AmeriHealth New Jersey 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: AmeriHealth New Jersey's current contract templates comply with the provisions. AmeriHealth New Jersey continues to enhance AmeriHealth New Jersey's communications strategy to notify providers and outline the required changes for any legacy contracts.

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

Q: How will insights on market pricing affect provider contract negotiation strategies?

A: To be determined. There may be providers who attempt to take advantage of the public data and compare this to their reimbursement; however, AmeriHealth New Jersey 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 New Jersey does not foresee any implications as the fee-for-service rates are the rates that are required to be published.

Q: Do AmeriHealth New Jersey's online provider directories comply with the requirements of the CAA?
A: AmeriHealth New Jersey's online provider directories comply with the CAA's requirements.

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

Miscellaneous Questions

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

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

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

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

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

Q: While the requirement for pharmacy benefit and drug cost reporting has been delayed, it is expected that further guidance will be issued, and plans should prepare to comply by December 27, 2022. Is AmeriHealth New Jersey continuing to develop this file based on current guidance and make adjustments when further guidance is issued?

A: AmeriHealth New Jersey is continuing to develop the process based on current requirements and will comply by the compliance date. The process will be adjusted once additional guidance is issued.

Q: Does AmeriHealth New Jersey expect to be a "reporting entity" and is AmeriHealth New Jersey able to support aggregate reporting at the state level of all required medical data elements on behalf of customers pursuant to the 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 New Jersey will be a "reporting entity" and will produce reports based on RxDC reporting instructions, including aggregate spending amounts based on required categories.

Q: As a service provider, is AmeriHealth New Jersey providing any brokerage or consulting services as defined by the statute?

A: No.