TRANSPARENCY IN COVERAGE RULE AND CONSOLIDATED APPROPRIATIONS ACT FAQS

BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

OCTOBER 11, 2021

MASSACHUSETTS

Contents

Introduction

Blue Cross Blue Shield of Massachusetts (BCBSMA) continues to actively plan our support of and compliance with the required capabilities for applicable provisions within both the Transparency in Coverage Rule (TCR) and the Consolidated Appropriations Act (CAA). However, significant legislation and regulations like these are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, BCBSMA can provide some insight as to our process, and we will, of course, work to provide more information as it becomes available to ensure compliance with regulatory deadlines and support our accounts.

As we continue to wait for further clarification on final regulations and rulemaking, we have been taking actions and assessing required activity based on reasonable assumptions. We are providing good faith responses to the best of our ability and reasonable interpretation thus far. It's important to note that we will adjust our approach as we receive further clarification and/or changes to the requirements as they are made by the federal government. We will continue to provide updates as we receive more information by updating this document and posting updated versions on our broker and account portals.

MASSACHUSETTS

Transparency in Coverage Final Rule (TCR) **UPDATED 10/11/21**

On November 12, 2020, the United States Departments of Health and Human Services (HHS), Labor and Treasury issued a Final Rule entitled Transparency in Coverage (the Rule). The Rule aims to increase the availability and transparency of health care price information to consumers to enhance market competition and lower health care prices. 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 Rule places requirements on fully-insured group health plans and self-funded accounts, and health insurance issuers in the individual and group markets. It also applies to Qualified Health Plan (QHP) issuers and the Federal Employees Health Benefits Program. The Rule does not, however, apply to Medicare Advantage, Medicare Supplement, Medicaid MCO coverage, or vision- or dental-only plans. Nor does the Rule apply to grandfathered health plans or to short term, limitation duration insurance. We do of course encourage accounts to consult with their legal counsel to determine if their plan is excluded if they are unsure.

The Rule's two (2) core requirements are to:

1. Disclose to the public [i] in-network provider negotiated rates, [ii] historical out-of-network allowed amounts, and [iii] drug pricing information through three (3) separate machine-readable files (MRFs) posted on an internet website.

   Important Update: The Departments have acknowledged that the subsequent CAA requirements, particular to prescription drug reporting, significantly changed the regulatory landscape since the TCR Final Rules were adopted. In particular, the Departments recognized concern about potentially duplicative and overlapping reporting requirements for prescription drugs.

   As a result, the Departments will now defer enforcement of the prescription drug MRF while it considers, through future notice/comment rulemaking, whether this particular requirement remains appropriate.

   In addition, The Departments will defer enforcement of the TCR Final Rules' requirement to publish in-network (IN) negotiated provider rates and the historical allowed amount payments to out-of-network (OON) providers until July 1, 2022.

2. 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 or by telephone if requested.

The Rule adopts a three-year, phased-in approach for compliance with the Rule, which requires Plans and Issuers to provide:

- Public access to the in-network and out-of-network machine-readable files for plan (or policy) years that begin on or after July 1, 2022;
- Cost-sharing information to participants, beneficiaries, or enrollees for 500 specified items and services for plan (or policy) years that begin on or after January 1, 2023; and
- Cost-sharing information to participants, beneficiaries, or enrollees for all covered items and services for plan (or policy) years that begin on or after January 1, 2024

Further, in asserting that these initiatives will enable enhanced public access to health coverage information and that can potentially dampen the rise in health care spending, the Rule will also allow (but not require) health insurance issuers to receive credit in their Medical Loss Ratio (MLR) 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 Questions and Answers

Does the rule apply to insurers and group health plans?

Yes. The rule applies directly to health insurers and to group health plans. The health insurer is responsible for implementing the requirements for fully insured group health plans.

A self-funded group health plan may contract with a third-party administrator to implement some or all requirements of the rule on behalf of the plan.

These rules do not apply to grandfathered plans, any group health plan or individual coverage in relation to the provision of excepted benefits (i.e., standalone vision, and dental plans), Personal Spending Accounts (i.e., HSAs, FSAs, HRAs, etc.) or other account-based group health plans, short-term limited-duration (STLD) insurance, Transitional Relief Plans, Medicare, and Medicaid.

We encourage accounts to consult with their legal counsel to determine if their plan is excluded if they are unsure.

Machine-Readable Files

What changes did the Tri-Agencies make to the Machine-Readable File requirements? **UPDATED 10/11/21**

The Departments will defer enforcement of the Transparency in Coverage Final Rules' requirement that plans/issuers publish MRFs relating to Rx drug pricing while it considers, through future notice/comment rulemaking, whether the Rx drug MRF requirement remains appropriate.

The Departments will defer enforcement of the TCR Final Rules' requirement to publish in-network (IN) negotiated provider rates and the historical allowed amount payments to out-of-network (OON) providers until July 1, 2022. Following this six (6) month delay, the Departments intend to begin enforcement on July 1, 2022, for anniversary dates (in the individual market, policy years) on or after January 1, 2022. For 2022 plan years and policy years beginning after July 1, 2022, plans and issuers should post the MRFs in the month in which the plan year (in the individual market, policy year) begins, consistent with the TCR Final Rules.

Given this updated guidance, BCBSMA will delay publishing the in-network and out-of-network files until July 1, 2022.

What are the dates for each provision of the rule for compliance? UPDATED 10/11/21

For public disclosure of machine-readable files (Effective for plan years (or policy years, as appropriate) on and after July 1, 2022), health plans must make publicly available two machine readable files: 1) the in-network (IN) negotiated rates with their providers; and 2) the historical payments to out-of-network (OON) providers and their billed charges. These files must follow a standardized format and be updated monthly. Through future notice, rulemaking/comment the Departments will determine if the Rx Drug pricing file remains appropriate

What are the requirements for July 1, 2022? UPDATED 10/11/21

The final rule requires health plans to provide publicly two separate machine-readable files that include pricing information: 1) the IN negotiated rates with their providers; and 2) the historical payments to OON providers and their billed charges. These files must be made accessible via a public website at no additional charge, cannot require a log-in or account, and be updated monthly. The files must, in part, also include plan option/coverage identifier information; billing codes to identify items and services for claims processing; and all applicable rates.

Plans and issuers will display these data files in a standardized format and will provide monthly updates. The historical prices are for the 90-day time-period that begins 180 days prior to the file publication date.

The TCR requires plans to make available to the public (including consumers, researchers, employers, and other third parties) two separate machine-readable files that include detailed negotiated prices related to in-network and out-of-network information. Please outline your intention to support this initiative and ability to update it monthly. UPDATED 10/11/21

BCBSMA is making good faith efforts in meeting all compliance requirements. We intend to be compliant with the requirements of the rule. We intend to build, generate, and publish files with the data that we have accountability for on behalf our of customers on a monthly basis as required by the rule.

The first file will show negotiated rates for all covered items and services between the plan or issuer and in-network providers. The second file will show both the historical payments to, and billed charges from, out-of-network providers. Historical payments must have a minimum of twenty entries to protect consumer privacy. Plans and issuers will display these data files in a standardized format and will provide monthly updates. Please note, we do not intend to support arrangements that are carved out of the BCBSMA programs (i.e., carve out Behavioral Health Care).

Can you describe the specific services that you will provide to both fully insured and self-funded accounts to ensure they are fully compliant with machine readable requirements? UPDATED 10/11/21

BCBSMA will support the components of the Transparency in Coverage Rule including the Cost Estimation Tool and the Machine-Readable Rate Files. The exception to this support is carved out benefits, such as, carved our Behavioral Health services.

BCBSMA is actively assessing both the TCR and the CAA and planning our support of and compliance with the required capabilities. However, significant legislation and regulations like these are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this stage of implementation, given the ongoing adjustments by the

departments it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

What is the date machine-readable files must be available publicly? UPDATED 10/11/21

The Departments intend to begin enforcing the requirement that plans and issuers publicly disclose information related to in-network rates and out-of-network allowed amounts and billed charges on July 1, 2022, for plan years (in the individual market, policy years) beginning on or after January 1, 2022. For 2022 plan years and policy years beginning after July 1, 2022, plans and issuers should post the MRFs in the month in which the plan year (in the individual market, policy year) begins, consistent with the TCR Final Rules.

What format should the data be displayed according to the requirements? UPDATED 10/11/21

Data files must be displayed in a standardized format and must be updated monthly.

Based on the technical guidance issued by the Centers for Medicare and Medicaid Services (CMS), we intend to utilize a JSON format.

Will BCBSMA create, maintain, and generate the publicly accessible website with all required machine-readable files on behalf employer clients?

BCBSMA intends to build and manage the publicly accessible website with the machine-readable files for data we have (in-network, out of network, and carved in pharmacy data). For accounts wishing to post these files on a separate website, we will establish a mechanism that will allow accounts to get appropriate access to support linking to the files BCBSMA will provide.

Will you only provide your data, or will your platform allow for merging other vendor's data (e.g., PBM, specialty network, etc.)? UPDATED 10/11/21

At this time, for July 1, 2022, we will only provide our data and data we have control of and will not include or merge other vendor's data. Data from account contracted third parties will not be included.

How often will data be updated?

Data will be updated in compliance with the regulations on a monthly basis.

When will your platform be ready to launch? Will you indemnify the plan for any penalties caused by a delayed launch?

We plan to make the file available in conjunction with the required due dates of the TCR. BCBSMA is actively assessing both the TCR and the CAA and planning our support of and compliance with the required capabilities. However, significant legislation and regulations like these are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

How will you provide the data files to the employer for consumption? FTP site, secure file sharing (HTTPS), other?

We will provide links to the files on our site. If employers would like to also post information on their site, they will have the capacity to link to our public website.

How will employers be able to direct inquiries to the website (i.e., can it be direct or via a link on the employer's site)?

We will provide links to the files on our site. If employers would like to also post information on their site, they will have the capacity to link to our public website.

Please confirm a website where files will be available.

This is not yet available. We will include the website and location of the files in a future communication.

Does anyone wanting to access the machine-readable file have to open a user account?

Machine-readable files will be publicly available to all users. Account logins and passwords will not be required.

How will BCBSMA respond to questions regarding any missing values such as NPI, procedure codes, etc.?

We will update accounts upon further clarification of our procedures to support how we will research and access any data discrepancies as identified.

If an account opts to engage with a third party (such as a data warehouse or healthcare pricing vendor for enrolled members) to ensure compliance with the federal requirements, will your organization provide all necessary data elements to the third party? Can you elaborate on how you will interface with third parties? UPDATED 10/11/21

BCBSMA will make any data mandated to be publicly available (i.e., in-network and out-of-network rate files) for public access and third-party developers will have access to this data. We do not intend for third party vendors to have unlimited access to BCBSMA's full load of data but with agreed upon parameters and guardrails we will comply with appropriate third-party requests from vendors and assess on an individual basis. We will share more information as it becomes available.

How often will the data for the machine-readable files be updated?

Data will be updated in compliance with the regulations monthly.

Please specify the data file format (e.g., JSON, XML, YAML, etc.)

Our data file format will be JSON.

What naming convention will BCSMA use for the files?

We intend to comply with the standard file naming convention based the rules at the time of publication.

Please share how BCBSMA will comply with the discounted rates disclosure requirements starting in 2022, specifically in the three separate files available on your website.

We intend to build, generate, and publish files with the data that we have accountability for on behalf our of customers on a monthly basis as required by the rule. BCBSMA is making good faith efforts in meeting all compliance requirements. We intend to be compliant with the requirements of the rule.

BCBSMA is actively assessing both the TCR and the CAA and planning our support of and compliance with the required capabilities. However, significant legislation and regulations like these are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

How will the requirements outlined in the TCR impact contracts with plan sponsors? Please note which provisions from the TCR will be addressed in plan-sponsor contracts.

BCBSMA is actively assessing both the TCR and the CAA and planning our support of and compliance with the required capabilities. However, significant legislation and regulations like these are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

Are there any unique challenges to providing the prescription drug machine readable file for January 1, 2022? UPDATED 10/11/21

Based on the recent Tri-Agency FAQ's, enforcement of the prescription drug machine readable file has been deferred; we will continue to monitor for further rulemaking on future requirements and timelines.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

BCBSMA has not made any determination regarding the potential of administrative fees as a result of these changes as we are evaluating the impact of Surprise Billing legislation on administrative costs.

Personalized Disclosure of Out-of-Pocket (OOP) Costs (Effective January 1, 2023, and January 1, 2024): **UPDATED 10/11/21**

The Transparency in Coverage Rule (TCR) requires insurers and plans to provide consumers with personalized cost-sharing information for both medical and prescription drugs, including estimates of their out OOP costs by service via an on-line tool, or paper, if requested. The Tri-Agencies recently

issued an FAQ that indicates they expect to fold the CAA Cost Tool requirement to support cost estimation via the phone into the TCR.

In general, the tools must make cost estimates available in real time via website and telephone, and within two business days in paper form. Members need to be able to have access to their estimated cost-sharing liability for a covered service by a specific provider(s) or billing code/descriptive term, and such estimated cost-sharing liability needs to reflect any cost-sharing reductions the member would receive. The cost estimator tool must also allow members to compare costs across both in-network and out-of-network providers, as well as provide accumulated amount for deductible and/or out-of-pocket maximum at the time of the estimate request.

Beginning with plan years on or after January 1, 2023, the cost estimator tool must disclose information on 500 items, services and prescription drugs identified in the final rule. Starting with plan years on and after January 1, 2024, the tool must list all covered items and services including prescription drugs.

Under the Transparency in Coverage Rule, what information must be included for consumers in the tool?

Health plans must make estimated personalized out-of-pocket costs information available to consumers along with the underlying negotiated rates for all covered items and services and out-of-network (OON) allowed amounts through a cost comparison self-service tool and in paper form if requested. Cost estimates will need to reflect current available information, indicating the consumers' financial liability for their healthcare items and services from providers of interest. The intent is to give consumers the opportunity to understand healthcare costs and their estimated cost-sharing liability based on their benefits and deductible and/or out of pocket accumulations, as well as the opportunity to compare costs across providers before obtaining care. According to the Transparency in Coverage rule, the cost estimator tool must be available to participants, beneficiaries and enrollees or their authorized representative. The tool must: include both in and out of network estimated cost; allow members or personal representatives to search based on billing code or description of the billing code; advise members of their current status towards deductible, out of pocket maximums and their accumulations to date; and provide cost estimate in paper format at the member's request.

What the is due date for consumers to have access to this information?

- January 1, 2023: an initial list of 500 shoppable services as determined by the Departments for plan years that begin on or after January 1, 2023.
- January 1, 2024: the remainder of all items and services will be required for plans years that begin on or after January 1, 2024.

Will BCBSMA be prepared to be compliant with the requirements of the TCR?

BCBSMA is making good faith efforts in meeting all compliance requirements. We intend to be compliant with the requirements of the rule. We expect to be prepared to support the self-service tool requirements for covered services for fully insured and self-funded accounts for both TCR and CAA as per the rules and future rulemaking.

What does all items and services include?

Beginning on and after January 1, 2024, the disclosure requirement for the cost comparison tool expands to all medical care covered by the insurer or plan including charges in connection with office visits, virtual care, medical tests, durable medical equipment, and prescription drugs.

How do consumers benefit from having access to a cost comparison tool?

There are several benefits of cost comparison tools as they relate to the consumer experience. Access to cost comparison tools allows consumers to shop for care, compare the cost and quality across providers and select providers that are best for themselves and/or family members. Members have greater insight to their potential out of pocket costs which allows them to prepare for the care they need while managing their finances. Understanding the cost of care in advance of receiving services, enables consumers to make informed an confident healthcare decisions and eliminates cost surprises which lead to negative experience and dissatisfaction.

Do you have a cost estimator tool today? If so, please describe your current cost estimation capabilities.

We provide members access to quality and cost information through our integrated decision support platform Find a Doctor & Estimate Costs. Find a Doctor & Estimate Costs provides members with access to our enhanced level of cost estimates that integrates total costs (average allowed amounts) based on our Blues-negotiated rates and 12 months of historical claims data with member-level benefits and deductible/out-of-pocket maximums to calculate an estimate of out-of-pocket liability. The historical data is derived from the Blue Cross Blue Shield Axis® (BCBS Axis®) database, which is a nationwide repository of over 75 million claims that is updated semi-annually by all Blue plans.

Cost data is captured at the episode level, factoring in facility, professional and technical costs, to give a more realistic sense of cost. Costs displayed are the average allowed amounts, based on Blue Cross-contracted rates. The same provider quality data available through provider search is also integrated with cost data.

Written Estimates
Members who want more detail can use a simple online form to request a written estimate. To make sure estimates are as accurate as possible, we contact providers to get specific procedure and diagnosis codes. Massachusetts Collaborative also developed a Cost Estimate Worksheet that's useful for both patients and providers to ensure that they have all the necessary codes prior to requesting the written estimate.

Consolidated Appropriations Act, 2021(CAA) **UPDATED 10/11/21**

The Consolidated Appropriations Act, 2021 ("CAA") was signed into law in late December 2020. The sprawling legislation contains billions of dollars in additional stimulus funding in response to the COVID-19 pandemic, numerous tax law and benefit changes, as well as a wide-ranging set of health care legislation, among other areas of focus. With its enactment has come a considerably tight timeframe for implementation processes, with an effective date for many health care-specific provisions set for January 1, 2022 – and which has been further complicated to this point by a lack of critical regulatory guidance. The Tri-Agencies recently released a FAQ, that modified timelines of some components of the CAA. These variations are indicated below.

Such provisions, as discussed in more detail further below, include:

- **Surprise Medical Billing Patient Protections**. Beginning Jan. 1, 2022, patients will be protected from surprise medical bills that could arise from out-of-network emergency care, certain non-emergency ancillary services provided by out-of-network providers, and non-emergency services performed by an out-of-network provider at an in-network facility without the patient's informed consent.
    - Provider Reimbursement and Independent Dispute Resolution (IDR) Process. Providers not satisfied with the initial payment amount for surprise claims, may initiate negotiation of the paid claim with the payer. If a negotiated settlement cannot be reached, the IDR process may then be triggered by either party. Each party will submit a final offer for consideration by the arbiter (also known as "baseball-style arbitration"), along with supporting information. The IDR entity makes the final binding decision.
    - Application of Protections to Ambulance Services. Patients 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.
- **Advanced Explanation of Benefits**. Requires individual and group health plans to provide an Advanced Explanation of Benefits ("AEOB") for scheduled services that includes a patient's information regarding network inclusion, contracted rate for a given item or service, out-of-pocket estimates, estimates of incurred amounts towards one's deductible/cost-sharing limits, and information on medical management requirements. The Tri-Agencies have recently deferred enforcement of this requirement and have indicated they will issue future rulemaking to support the future capabilities and timelines.
- **Price Comparison Tool**. Separate from the Transparency in Coverage Rule, the CAA requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider. The Tri-agencies recognized that the Price Comparison Tool overlaps the requirements under the Transparency in Coverage rule and therefore have aligned delivery to January 1, 2023. They have also indicated they expect rulemaking to add the requirement to deliver the tool by phone, which is not currently included in the Transparency in Coverage guidance.
- **Continuity of Care**. For certain levels of care, Plans are required to give members the opportunity to request a transitional care period if a health provider is removed from a plan's network following termination of the network contract between the plan and provider.
- **Mental Health and Substance Abuse Parity**. Requires group & individual health plans and Medicaid managed care organizations to perform, document and to provide upon request

comparative analyses of the design and application of non-quantitative treatment limitations (NQTL).

- **Enhanced Provider Data Requirements.** Requires commercial 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.
- **Changes to ID Cards**. Plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the plan or coverage, 1.) any deductible applicable to the plan, 2.) any maximum out of pocket limits applicable to the plan, 3.) telephone number, and internet website address where an individual can seek consumer/member assistance.

Consolidated Appropriations Act, 2021 (CAA) Questions and Answers

Surprise Billing **UPDATED 10/11/21**

Title I of Division BB of the CAA (the No Surprises Act) within the CAA establishes new protections from surprise billing and excessive cost-sharing for consumers receiving certain health care items and services.

- Protects members from balance billing when receiving certain services under certain circumstances.
- Provides for patients to be responsible for only in-network cost-sharing amounts, and requires claims be applied to in-network cost-sharing, including deductibles and out-of-pocket maximums, in certain emergency and non-emergency situations.
- Also applies to air ambulance services (ground ambulance services excluded).

In addition to the prohibitions on surprise billing, the No Surprises Act requires providers and insurers to negotiate provider payments should either party not be satisfied with the proposed rate of payment. If the insurer and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) process, also referred to as arbitration, will be deployed to determine the reimbursement amount

This provision takes effect January 1, 2022, and applies to all individual, small group, and large group fully insured markets and self-insured group plans, including grandfathered plans (excludes Medicare)[1].

Please confirm you will be compliant with the Transparency and No Surprises Act as outlined as outlined in the regulations.

BCBSMA is assessing all components of CAA and developing implementation plans structured to advance BCBSMA compliance with the law and regulations no later than the effective date. The legislation, passed at the end of 2020, has been followed by Interim Final Rules, published 7/13/21, and further rulemaking is anticipated. BCBSMA will continue to monitor additional guidance issued at the regulatory level and as needed, refine implementation plans and craft alternative solutions as best as possible.

[1] Individual (non-ERISA), Church (non-ERISA), Muni (non-ERISA), Labor, Student, small and large Commercial Group Plans (fully insured, self-insured, and grandfathered), FEP, TPA

Under the No Surprises Act, the CAA will require 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?

BCBSMA is engaged in multiple activities at the enterprise, functional, and operational levels structured to comprehensively address the various components of the CAA related to Surprise Billing, and to assure the plan is positioned as best as possible to support the requirements of the law. Activities underway address the five foundational elements of Surprise Billing provisions of the law: services protected from balance billing, payment to out-of-network providers for such services, cost-sharing requirements, negotiation between out-of-network providers and payers, and the Independent Dispute Resolution (IDR) process.

What is BCBSMA's expected timing in accordance with the new regulations? UPDATED 10/11/21

BCBSMA is engaged in research, planning, and implementation activities with the goal of achieving implementation by 1/1/22, the effective date of the law. Regulations addressing the Surprise Billing component of the CAA were published 7/13/21, and additional regulations are expected to follow. BCBSMA will continue to work to meet the requirements of the regulations to achieve compliance with the effective date.

How will shared savings arrangements be impacted by the Surprise Billing regulations?

At this time, BCBSMA does not anticipate modifying the structure of shared savings arrangements as a result of Surprise Billing regulations. As with any forecasted or actual change to payment and utilization metrics, costs and budgets may be impacted.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

BCBSMA has not made any determination regarding the potential of administrative fees as a result of these changes as we are evaluating the impact of Surprise Billing legislation on administrative costs.

Which entities will fulfill the role of IDR (independent dispute resolution)? Is this different from the entity that you currently contract with to negotiate disputed claims?

In accordance with the CAA, the federal government has accountability for certifying and selecting IDR entities that payers and providers may use. From the approved list, payers and providers together will choose one IDR entity for each particular case or group of cases. If agreement cannot be reached on the IDR entity, the federal system assigns the IDR entity for each specific case or bundle of cases.

Please indicate your intent to comply with the Independent Dispute Resolution Process.

BCBSMA intends to be compliant with IDR provisions of the law by the effective date. Final regulations have not yet been published.

Please describe how cost of IDR will impact self-insured clients (for example, pass through claim cost or PEPM admin fee)?

BCBSMA currently is exploring whether fees or charges associated with the IDR process would be charged back partially or in full to self-insured accounts as a claims cost or an administrative fee.

How will BCBSMA ensure members are protected from balance bills where legislation requires that protection? Specifically, when plan participants encounter the following situations. Please provide specific recommendations, if available (i.e., cap reimbursement at % of Medicare).

- **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**

BCBSMA intends to implement all provisions of the law that are required of health plans to achieve compliance and plans to process and adjudicate out-of-network claims as required by the law. Regardless of the amount BCBSMA reimburses the provider upon initial payment, the provider is prohibited from balance billing for certain services included under CAA without member consent. If dissatisfied with the amount of payment, the provider may elect to negotiate with the payer, and if still seeking additional payment may proceed to IDR.

Although it is the responsibility of the provider not to balance bill under all circumstances covered by the law, health plans are required to implement systems to help support the intent of the law. BCBSMA is developing processes that will, for example, (i) assure plan designs comply with cost-sharing components of the law; (ii) identify claims falling under the scope of the law; (iii) adjudicate such claims in accordance with the law; (iv) generate and apply a Qualifying Payment Amount (QPA) reflecting the requirements of the law; and (v) facilitate claims negotiation and engagement in the IDR process.

Can you provide guidance on how BCBSMA is addressing surprise billing requirements?

BCBSMA, is conducting an enterprise-wide implementation effort designed to achieve compliance with Surprise Billing legislation by the applicable effective date. BCBSMA is deploying a broad base of policy, operations, and technological resources to meet the requirements of the law and has active workgroups across the company working towards compliance with different surprise billing requirements. At a more specific level, BCBSMA is, for example, modifying system processes to identify claims that are covered by the law, configuring cost-share calculations that reflect the new requirements, developing methodologies for determining the Qualified Payment Amount (QPA), and evaluating approaches to negotiation and IDR to support effective and efficient processes in support of our accounts and members.

For out-of-network services, provide recommendations on reasonable and customary limits to protect the plan from fraud, waste and abuse and members from balance billing. In particular, do you recommend adding a reasonable and customary level of reimbursement for out-of-network facility charges (i.e., 150% of Medicare)? How will BCBSMA protect members from balance billing with this limit?

For fully insured and self-insured PPO plans with out-of-network benefits, BCBSMA offers an out-of-network payment methodology designed to protect the plan from fraud, waste, and abuse and members from balance billing. Such methodology utilizes fair, reasonable, geographically adjusted, credible fee schedules as well as a program for negotiating out of-network fees where possible. Our standard design prices claims at Medicare 150%. When no Medicare rate is available, the claim is then priced using a third-party proprietary fee schedule meeting the attributes noted above. While members could be balance billed, the rate of payment is designed to be appropriately priced thereby discouraging balance billing. BCBSMA also offers accounts a charge-based option and a Medicare 300% option. For the charge-based option and Medicare 300% claims for which there is no Medicare fee, eligible claims

are negotiated on a pre-payment basis and all successfully negotiated claims include a ban on balance billing.

Under the Surprise Billing Law, certain providers cannot balance bill members regardless of the amount of the health plan's initial payment. Should the provider wish to challenge the amount of the initial payment, the provider is required to negotiate and if not satisfied then submit the matter to Independent Dispute Resolution (IDR).

The Surprise Billing regulations have an exception – if providers have given patients 72-hour notice of their network status and an estimate of charges. Please explain how BCBSMA will know that a provider/facility has a waiver to balance bill patients. Please also confirm there will be operations in place to process these claims appropriately. UPDATED 10/11/21

Surprise Billing legislation only allows balance billing by certain providers, for certain services covered by the law, where the provider secures written consent from the patient at least 72 hours prior to the service.

The CAA requires providers notify health plans when notice and consent requirements have been satisfied by the provider and submit supporting documentation to the health plan. In compliance with the law and any current or future requirements, BCBSMA is developing procedures to operationalize receipt of notice, notice review and retention requirements, and proper payment of the claim, including adjustments necessary when appropriate notice is received. These procedures will be operationalized in accordance with the requirements of the CAA.

Confirm you will be amending your fully-insured plan designs to be in compliance with the No Surprises Act (e.g., the requirement to cover emergency services provided in or out of network without any prior authorization and to cover OON emergency services as if they were received in-network).

BCBSMA will be modifying fully-insured plan designs to the extent required by the legislation and accompanying regulations.

Do you anticipate any claims impact resulting from the No Surprise Billing provisions?

BCBSMA does anticipate there will be an impact to claims costs and processing as a result of implementing the surprise billing components of CAA but continues to review the matter as additional guidance and regulations are issued.

Advance EOB (AEOB) **UPDATED 10/11/21**

Effective January 1, 2022, the CAA requires providers and facilities to verify what type of coverage the patient is enrolled in and provide notification of a good faith estimate to the payer (if the patient is enrolled in a plan or insurance coverage and intends to use the coverage) three days in advance of a scheduled service. The AEOB will be triggered by the notification from the provider and/or facility or upon request of the patient of authorized representative. Individual and group health plans will be required to provide an advance EOB for scheduled services at least three days in advance of a service. If the service is scheduled within three days of the request, the AEOB must be provided to the member within one business day and if the service is scheduled within 10 days of the request, the AEOB must be provided within three business days.

Advanced EOBs are to be delivered to members either electronically or via postal mail, as requested by the member and include service details received from the provider(s); the providers' network status; negotiated rate information and actual plan liability for the service; a good faith estimate of the member's cost-sharing liability for the service; and any relevant disclaimer information on medical management requirements that apply to the service.

Important Update: Given concerns from stakeholders regarding the ability to build good faith estimates as noted above, the Departments now acknowledge that AEOB compliance is likely not possible by 1/1/22. The Departments intend to develop a new notice and rulemaking process to implement this provision; until that time, Departments will defer enforcement of AEOBs. Consistent with other carriers, BCBSMA is awaiting further direction and clarification from the Departments on specifics of this provision.

Please confirm what BCBSMA's plans for accommodating the CAA requirement to provide advance EOBs to members in 2022? UPDATED 10/11/21
Consistent with other carriers, BCBSMA is awaiting further direction and clarification from the Departments on specifics of this provision.

How will you provide the data to the employer or their third-party vendor to enable them to comply? UPDATED 10/11/21

As of 8/20/21, the Tri-Agencies have deferred the AEOB mandate until they develop a new notice and rulemaking process. Therefore, the January 1, 2022, implementation date has moved pending additional guidance. We intend to comply with the requirements and will follow-up with more details as they are clarified.

Will BCBSMA be able to comply with requests by phone/email or requests for paper copies within the timeframe required? UPDATED 10/11/21

As of 8/20/21, the Tri-Agencies have deferred the AEOB mandate until they develop a new notice and rulemaking process. Therefore, the January 1, 2022, implementation date has moved pending additional guidance. BCBSMA will provide an on-line submission process and responses will be provided based on the member's electronic/paper preference if required as part of the final requirements. BCBSMA intends to comply with the requirements and will update our approach as new information is obtained.

When will your platform be ready to launch?

BCBSMA is making good faith efforts in meeting all compliance requirements. We intend to be compliant with the requirements of the CAA.

Please note whether your current cost comparison tool(s) will be leveraged in meeting the advanced EOB requirement. UPDATED 10/11/21

As of 8/20/21, the Tri-Agencies have deferred the AEOB mandate until they develop a new notice and rulemaking process. Consistent with other carriers, BCBSMA is awaiting further direction and clarification from the Departments on specifics of this provision.

Will you incorporate data from carve-out vendors such as pharmacy benefit managers into advance EOBs? UPDATED 10/11/21

Consistent with other carriers, BCBSMA is awaiting further direction and clarification from the Departments on specifics of this provision.

Please confirm BCBSMA will be ready to deploy an internet-based self-service tool for members to receive their advanced EOBs. UPDATED 10/11/21

BCBSMA intends to comply with the mandate requirements and will update our approach as new information is obtained. Digitally, the Advance EOB would be available for members to view in their MyBlue account. Advance EOB responses would be provided based on the member's electronic/paper preference.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

We have not made any determination regarding the potential of administrative fees as a result of these changes as we are still assessing our approach. We will follow-up with relevant stakeholders as we determine our approach.

Cost Comparison Tool **UPDATED 10/11/21**

Requires group health plans and health insurance issuers to maintain a "price comparison tool" available via phone and website that allows enrolled individuals and participating providers to compare cost-sharing for items and services by any participating provider.

The regulations on price comparison tools outlined in the CAA have been determined to be duplicative of those that are outlined under the Transparency in Coverage final rule. Therefore, the consumer tool requirements will begin in alignment with existing TCR language for price comparison tools for the HHS-determined 500 items/services, on and after January 1, 2023.

- BCBSMA will continue its work to expand cost estimation to our Indemnity members and certain accounts which do not currently have access to our Estimate Costs tool and will add an additional 106 treatment categories effective January 1, 2022.

- Alignment of the CAA requirement that price information must also be provided over the telephone upon request (not included in TCR), is intended to be addressed via new rulemaking within the TCR wherein the same pricing information that is available through the online tool or in paper form is also provided over the telephone upon request.

Although final guidance is still needed and there is some overlap with the TCR, can you confirm if BCBSMA will create, maintain, and provide access to the comparison tool for members and accounts? UPDATED 10/11/21

BCBSMA has a longstanding commitment to health care transparency. Engaging our members in decisions around their care is critical as we work together with health care providers to improve quality, affordability, and patient centered care. We have cost estimation tools designed to help our members become more informed health care consumers and allow them to compare:

- The approximate cost of services and procedures that can be performed in a variety of settings (for example, hospital outpatient and inpatient, freestanding imaging centers, ambulatory surgery centers).
- Average costs for services performed in medical group offices, including physician-specific costs for outpatient and imaging services.

Please see the Cost Estimation section of the TCR in this document for more details.

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

The Cost Comparison Tool will be made available in the same manner it is today through our MyBlue website and app. Our Service staff has access to produce cost estimates on behalf of our members via the phone and written procedures.

Do you have a cost estimator tool today? If so, please describe your current cost estimation capabilities.

We provide members access to quality and cost information through our integrated decision support platform Find a Doctor & Estimate Costs. Find a Doctor & Estimate Costs provides members with access to our enhanced level of cost estimates that integrates total costs (average allowed amounts) based on our Blues-negotiated rates and 12 months of historical claims data with member-level benefits and deductible/out-of-pocket maximums to calculate an estimate of out-of-pocket liability. The historical data is derived from the Blue Cross Blue Shield Axis® (BCBS Axis®) database, which is a nationwide repository of over 75 million claims that is updated semi-annually by all Blue plans.

Cost data is captured at the episode level, factoring in facility, professional and technical costs, to give a more realistic sense of cost. Costs displayed are the average allowed amounts, based on Blue Cross-contracted rates. The same provider quality data available through provider search is also integrated with cost data.

Written Estimates
Members who want more detail can use a simple online form to request a written estimate. To make sure estimates are as accurate as possible, we contact providers to get specific procedure and diagnosis codes. Massachusetts Collaborative also developed a Cost Estimate Worksheet that's useful for both patients and providers to ensure that they have all the necessary codes prior to requesting the written estimate.

What are the benefits of the price comparison tools?

There are several benefits of cost comparison tools as they relate to the consumer experience. Access to cost comparison tools allows consumers to shop for care, compare the cost and quality across providers and select providers that are best for themselves and/or family members. Members have greater insight to their potential out of pocket costs which allows them to prepare for the care they need while managing their finances. Understanding the cost of care in advance of receiving services, enables consumers to make informed an confident healthcare decisions and eliminates cost surprises which lead to negative experience and dissatisfaction.

What are the search capabilities in the price comparison tool?

Members can search by treatment categories. We will have over 1,700 treatment categories when this launches. Members can filter and sort results and compare up to five providers side by side.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

We have not made any determination regarding the potential of administrative fees as a result of these changes as we are still assessing our approach. We will follow-up with relevant stakeholders as we determine our approach.

Continuity of Care

The new protections for defined patients in the midst of a course of medical care are effective for the first plan year beginning on or after January 1, 2022. The Act determines timely notification to a member if a health provider is removed from a plan's network following termination of the network contract between the plan and provider. When this occurs, the plan or insurer must notify members who are receiving care from the provider that:

- The provider is no longer part of the plan's network.
- The participant has the right to continue receiving transitional care from the provider.
- The plan must cover the transitional care provided by that former plan network provider at the in-network coverage level during the transitional care period.

Plans are required to give the participant the opportunity to request a transitional care period. The period must extend for the remaining time that the participant is a patient at a continuing care facility or for up to 90 days after the plan participant(s) receives notification from the plan that the provider is no longer in their network.

Please confirm your intention to allow certain participants 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.

BCBSMA is actively assessing the CAA and components related to the Continuity of Care provisions. It is our intention to comply with all requirements of the CAA. Significant regulations such as this are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

Will BCBSMA notify a "continuing care patient" in the event their in-network provider is losing their in-network status due to contract termination or plan change?

BCBSMA is actively assessing the CAA and components related to the Continuity of Care provisions. It is our intention to comply with all requirements of the CAA. Significant regulations such as this are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

Describe the process for that notification.

BCBSMA is actively assessing the CAA and components related to the Continuity of Care provisions. It is our intention to comply with all requirements of the CAA. Significant regulations such as this are

accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

Please comment on your expected timing in accordance with the new regulations.

BCBSMA is actively assessing the CAA and components related to the Continuity of Care provisions. It is our intention to comply with all requirements of the CAA. Significant regulations such as this are accompanied by a process of continued guidance and rulemaking by government agencies that will deliver further clarity. At this early stage of implementation, it is difficult for us to state with precision how BCBSMA will administer and process these changes and support our accounts. We will, of course, work with our accounts as more information becomes available to ensure compliance with regulatory deadlines.

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Mental Health Parity and Addiction Equity Act - CAA

Since passage of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), BCBSMA has conducted in-depth compliance assessments. These ongoing analyses were initially conducted when implementing the statute as well as the Interim Final Rule issued in February 2010 (in effect through June 30, 2014), and the Final Rule effective July 1, 2014. Additionally, as part of more recent federal guidance, BCBSMA reviews and updates MHPAEA compliance activities. This work effort includes ongoing non-quantitative treatment limitations (NQTLs) as highlighted in recent DOL guidance (April 2021).

Given the new 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, will you be offering services to support this?

Yes, BCBSMA conducts NQTL Comparative Analysis, based on federal law and guidance released by the Departments of Labor, Health and Human Services, and Treasury, and will make NQTL documentation available to the Department of Labor upon request.

Please comment on your expected timing in accordance with the new requirements.

BCBSMA continuously reviews and updates NQTL comparative documents.

Please delineate the impact, if any, on the administrative fees as a result of these changes.

BCBSMA does not charge a few for supporting DOL inquiries and DOL requests of information and NQTL documentation.

Provider Directories **UPDATED 10/11/21**

Requires group health plans and issuers offering group and individual health plans to establish a verification process to confirm directory information at least every 90 days. The requirements below are from the CAA legislative text and it is assumed further clarification, detail and date confirmation for compliance will be detailed in the regulatory text sometime in next few months. We are working to mitigate, and plan based on limited current information, and may need to adjust our roadmap based on further specifics. We will continue to update this document as we receive more details.

Important update: Until further rulemaking is issued, plans and issuers are expected to implement provider directory provisions using a good faith compliance approach. Pending any future implementing rulemaking, the Departments clarify that good faith compliance requires plans and issuers to impose in-network cost-sharing where a participant receives items or services from a nonparticipating provider and the participant was provided inaccurate information by the plan or issuer through a provider directory or other response protocol.

- Requires plans to establish a response protocol to respond to member network questions within one business day and retain communications for at least two years.
- If a member provides documentation that they received incorrect information, the patient will only be responsible for in-network cost-sharing.
- Requires providers to update directory information and provide refunds to enrollees (in certain circumstances).
- Requires update of directory information within 2 business days of plan or issuer receiving from a provider or facility information.
- The data elements that must be updated in directory information are defined by the CAA:
    - For purposes of this subsection, the term ‘provider directory information’ includes, with respect to a group health plan and a health insurance issuer offering group health insurance coverage, the name, address, specialty, telephone number, and digital contact information of each health care provider or health care facility with which such plan or such issuer has a contractual relationship for furnishing items and services under such plan or such coverage.

Please share your roadmap for making available to participants up-to-date provider directories, and participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts. In your response, please confirm and outline your ability to conform to the requirement that participants who rely on incorrect information received will only be liable for in-network cost-sharing amounts.

Our provider directories are updated continuously, and date of update is noted. If data is incorrect and a member relies on the incorrect data and that is brought to our attention, we will initiate the appropriate claim adjustment to ensure the provider is made whole and the member is only held responsible for the in-network cost share.

Will you comply with the provider directory requirements on behalf of your employer clients?

Yes, BCBSMA is making good faith efforts in meeting all compliance requirements and our intention is to ensure full compliance with the CAA provider directory regulations.

How often will you update the directory?

We will comply with CAA requirements to validate and confirm provider data every 90 days. Additionally, we update our directory data as we receive information from providers and third-party vendors on a continual basis.

Will you notify employers of the update?

Given the frequency and volume of provider data changes we receive and process daily we will not be able to support account notification of updates but will ensure compliance with federal and state requirements for managing and presentment of provider directory information. We make available an online version of our directory that includes real time updates and date changes were made.

Will the versions be dated, so employers will know the updates are current?

Our online directory does include date information indicating when provider information was updated.

How will access to the directory be provided (i.e., directly or via an employer website)?

Our online directory is available to members and prospective members via our portal (bluecrossma.org).

If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how BCBSMA will administer the claim at the in-network level?

If we determine incorrect provider network data was used in accessing care, we will ensure we are compliant with CAA and process the claim at the in- network level for patient cost share, and ensure the provider is made whole at the out of network payment level.

Please comment on your expected timing in accordance with the new regulations.

We are making good faith efforts to be prepared for the compliance date.

Please advise, if any, on the administrative fees as a result of these changes.

The work effort to be compliant with CAA and any other regulations is part of our overall administrative budget.

How will BCBSMA adapt internal processes to comply with the following requirements regarding accuracy of provider directories:

- **If the provider directory information is outdated and a member utilizes the incorrect information in seeking in-network care, please confirm how BCBSMA will administer the claim at the in-network level.**

If we determine incorrect provider data was used in accessing care, we will ensure we are compliant with CAA and process the claim at the in-network level for patient cost share, and ensure the provider is made whole at the out of network payment level.

ID Cards

Plans must include in clear writing on any physical or electronic identification cards that are issued to members or enrollees in the plan or coverage, 1.) any deductible applicable to the plan, 2.) any maximum out of pocket limits applicable to the plan, 3.) telephone number, and internet website address where an individual can seek consumer/member assistance.

Please indicate your intent to comply with ID card requirements to include deductibles, out-of-pocket maximums, phone number and website address to assist members.

BCBSMA intends to comply with the deductible and out of pocket maximum requirements. Phone number and web address are already included on the ID card.

Please confirm if new ID cards will need to be issued given the requirements to display INN/OON cost sharing and BCBSMA's ability to support this.

We expect to issue new ID Cards except for Medicare and Medex plans. Additionally, digital versions of the ID cards with the updated requirements will be made available on the MyBlue member portal. We are currently assessing both internally and with our ID card vendor our ability to support the 1/1/22 date.

Will you reissue ID cards to include deductible, in-network, and out-of-network out of pocket limits, telephone number, and internet website address where information is housed?

The reissued card will include the deductible and in/out of network information. The telephone number and website are already part of the BCBSMA card.

Please confirm no file changes/interfaces will be needed.

We do not expect any changes will be required of files currently being sent to BCBSMA by our customers. There will be a modification to the existing file sent to our ID card vendor. Assessment on data source and integration into the existing file is in progress.

When will new ID cards be reissued?

We are currently targeting 1/1/22 renewals and are working diligently with vendors to assess timing. We are also continuing to monitor the regulatory process in the event more details are provided by the federal government. Updates to the digital cards are also targeted for 1/1/22 or sooner but are dependent upon vendor ability to support.

Will there be a cost associated with reissuing ID card?

There will be no additional cost for reissuing the ID cards for our accounts or members.

What date does BCBSMA need renewal decisions to produce ID cards in a timely fashion?

We need 60 days in advance to produce ID cards by the required timeframe.

General Questions

Please describe how your organization is coordinating the cross-functional, enterprise-wide implementation of the TCR and CAA requirements.

We have a broad cross functional team that has been in place for several months assessing requirements from both the TCR and CAA to determine our steps and solutions to solve for all transparency requirements. As we review requirements and our role and responsibilities to implement solutions that allow us to be compliant, we have also created individual provision-specific workstreams across the enterprise to ensure our teams are looking at issues in the most in-depth and robust process possible.

How and when will updates on your compliance with the various requirements of the TCR and CAA be disseminated to accounts?

We are creating an external FAQ document which will be available to our accounts and brokers on our portals and will be updated on a regular basis as we receive further clarification and solidify our approach to solving for these multiple provisions within the TCR and CAA.

How will you use price transparency as an opportunity to improve the consumer experience?

Over the past decade, we have been focused on providing greater transparency through our tools and service and will continue to focus on providing meaningful cost transparency tools to our members. Based on consumer research and the voice of the consumer analytics and studies we've conducted over the years; we know that increased cost transparency before treatment will help address the pain point of unexpected costs and help members plan their finances better before receiving treatment. Members want to better understand their healthcare costs so that they can maximize the value of their health plan and make the best-informed decisions on where to access affordable healthcare and manage their healthcare finances. Providing members with improved and expanded access to price transparency will enhance the experience by allowing them to anticipate the cost of care easily and accurately before receiving treatment. Members will be empowered and feel confident making informed decisions on where to access the best care for themselves and families while avoiding cost surprises.

Will you support the employer's communication to their employees on these changes and new resources?

We expect to continue to help, inform, and educate our members and other stakeholders on these changes and any new available resources and capabilities. We will communicate our approach as this develops. While we will continue to support our self-funded accounts as we do today, self-funded accounts will still be responsible for communicating to their employees and sharing materials and information as it's available.

Please comment on BCBSMA's readiness and associated timing and plans for member communications for TCR & CAA requirements. Are there any new administrative requirements expected from ASC Accounts as the plan sponsor?

We expect to continue to help, inform, and educate our members and other stakeholders on these changes and any new available resources and capabilities. We will communicate our approach as this develops. While we will continue to support our self-funded accounts as we do today, self-funded accounts will still be responsible for communicating to their employees and sharing materials and information as it's available. Additionally, we will continue to monitor updates on the regulations as

there may be specific communication guidelines and expectations dictated by the TCR and CAA when published which may require specific activities for plans and self-funded accounts.