Provision

Machine Readable Files

Price Transparency Tool

Advance EOB

Provision

Surprise Medical Billing

QPA, Negotiation, IDR

Plan ID Cards

Advance EOB
External Appeals

Provider Directory

Continuity of Care

Choice of Healthcare Professionals

Transparency Tool

Disclosure Against Balance Billing

Provision

Removal of Gag Clauses

Reporting Pharmacy Benefits & Rx Costs

Mental Health Parity NQTL Reporting

Provision

Follow Up Colonoscopy

Contraceptives

Breastfeeding Services and Supplies

Screening for HIV Infection

Counseling for Sexually Transmitted Infections

Well-Women Preventative Visits

Transparency Rule
Overview

3 types of MRFs
1. Shows negotiated rates for all covered items and services between plan and in-network providers.
2. Shows historical payments to, and billed charges from, out of network providers.
3. In network negotiated rates and historical net prices for all covered prescriptions drugs.

The machine-readable files must be updated monthly and clearly indicate the last time they were updated.
This is a personalized out-of-pocket cost information and negotiated rates for all services and drugs.
500 shoppable services required by 1/1/23
All other services by 1/1/24.
Member initiated EOB - an estimate of the participant's cost-sharing liability for a requested covered item or service.

Consolidated Appropriations Act - No Surprises Act
Overview

The law applies to medical bills for covered services related to 1) OON emergency at a hospital or facility; 2) items and services provided by certain OON healthcare providers at INN facility; 3) OON air ambulance.

The QPA is used to calculate the recognized amount; it is generally the median of the specific payer's contracted rates for the same or similar service in that geographic region.
For these claims, if negotiations fail, an IDR process is available.
Requires in-network and out of network deductible and out of pocket maximum on ID cards. Requires phone numbers and the website address where members may obtain support and network facility and provider information.

Providers must ask patients if they have coverage when scheduling appointments and send estimated service/cost notice to plan. Then plan sends an Advance Cost Estimate (ACE) to member with estimated member responsibility.
Plan required to offer external review for surprise bill member disputes.

Plan must have process to verify provider information, respond to member inquiries on provider status. Requires verification process and written/electronic member response.
Plan must notify each enrolled individual under care by a participating provider when a provider terminates a contract and is no longer in the network and member must notify plan of need for continuation of care for certain conditions. The plan must allow the individual to continue benefits for up to 90 days and benefits will be paid at the same terms and conditions.

If a plan requires or provides for designation of a PCP, then the plan must permit each participant to designate any PCP who is available to accept the participant. Applies to pediatricians and obstetrical and gynecological care as well.
Shall offer price comparison guidance by telephone and make available on the Internet website of the plan a price comparison tool
Plans are required to make publicly available, post on a public website and include on each EOB.

Consolidated Appropriations Act - Transparency
Overview

Health care contracts shall not prohibit electronic access of provider information, access to de-identified claims and encounter information or sharing information with others.

Requires health plans to annually report information on prescription drug benefits and costs to the Departments. Information includes:
- General information regarding the plan or coverage;
- Enrollment and premium information, including average monthly premiums paid by employees versus employers;
- Total healthcare spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;
- The 50 most frequently dispensed brand prescription drugs;
- The 50 costliest prescription drugs by total annual spending;
- The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
- Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and
- The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.

Plans must develop and disclose to state and federal regulatory agencies information on NQTLs upon request.

Preventive Care Coverage Updates
Overview

Plans are required to cover a follow-up colonoscopy, without cost sharing, after a positive stool-based screening test or direct visualization test for all ages covered by the recommendation (i.e., people age 45 and older). The fact that a preliminary test came before the follow-up colonoscopy does not transform the colonoscopy into a diagnostic test; it (and the items and services noted above) remains a preventive service that should be covered without cost sharing.

Plans must cover, without cost sharing, all FDA-approved, cleared, or granted contraceptive products that are deemed medically appropriate by an individual's provider. This includes screening, education, counseling, and provision of contraceptives (including in the immediate postpartum period). Contraceptive care also includes follow-up care (e.g., management, evaluation, and changes, including the removal, continuation, and discontinuation of contraceptives).

Comprehensive lactation support services (including consultation, counseling, education by clinicians and peer support services, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods. These services are intended to ensure the successful initiation and maintenance of breastfeeding. The equipment and supplies include double electric breast pumps (including pump parts and maintenance) and breast milk storage supplies. Breastfeeding equipment may also include equipment and supplies as clinically indicated to support dyads with breastfeeding difficulties and those who need additional services.

Adolescent and adult women, ages 15 and older, will be able to receive a screening test for human immunodeficiency virus (HIV) at least once during their lifetime. Earlier or additional screening will be based on risk. Rescreening annually or more often may be appropriate beginning at age 13 for those at increased risk. Risk assessment and prevention education for HIV infection must be paid for beginning at age 13 and continuing as determined by risk. A screening test for HIV is recommended for all pregnant women upon initiation of prenatal care with potential rescreening based on risk. Rapid HIV testing is recommended for pregnant women who present in labor with an undocumented HIV status.
Plans and carriers will need to cover behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs). For those without identified risk factors, counseling to reduce the risk of STIs will be covered based on the provider's determination on an individual basis.
Plans will be required to cover at least one preventive care visit per year beginning in adolescence. Well-women visits also include pre-pregnancy, prenatal, postpartum, and interpregnancy visits.

Effective Date

7/1/2022
Pharmacy MRFs are deferred

500 shoppable services due 1/1/23
All other services by 1/1/24.

1/1/2023

Effective Date

Plan years beginning 1/1/22

Plan years beginning 1/1/22

Plan years beginning 1/1/22

Deferred Enforcement
Plan years beginning 1/1/22

Plan years beginning 1/1/22

Plan years beginning 1/1/22

Plan years beginning 1/1/22

Deferred Enforcement

Plan years beginning 1/1/22

Effective Date

Plan years beginning 1/1/22

12/27/2022 - Plans will report the required information for both 2020 and 2021 by December 27, 2022.

2/10/2021

Effective Date

Plan years beginning on or after 5/31/2022

Plan year beginning on or after 12/30/22

Plan year beginning on or after 12/30/22

Plan year beginning on or after 12/30/22

Plan year beginning on or after 12/30/22

Plan year beginning on or after 12/30/22